State of Vermont
Agency of Human Services

2021–2022 External Quality Review Technical Report

for

Department of Vermont Health Access

January 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Introduction and Summary of Findings

Background

The federal Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires state Medicaid agencies to "provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract."[1-1] Health Services Advisory Group, Inc. (HSAG), is under contract with the Vermont Agency of Human Services (AHS) to perform the external quality review (EQR) activities for the State.

The 2021 Vermont EQR Technical Report for the AHS complies with 42 Code of Federal Regulations (CFR) §438.364,[1-2] which requires the external quality review organization (EQRO) to produce an annual detailed technical report that summarizes findings on access to and quality of care including a description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity. This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other protected health information (PHI) of any beneficiary. The AHS quality strategy establishes standards related to access to care, structure and operations, quality measurement and improvement, performance objectives, provisions for external quality review, and mechanisms to monitor compliance with the standards and objectives set forth in the quality strategy.

To meet requirements established by the federal regulations and described in the AHS quality strategy, AHS contracted with HSAG to conduct the EQR activities beginning in the EQR contract year 2007–2008. This report covers the EQR activities conducted during 2021–2022, the EQR contract year. HSAG conducted the mandatory EQR activities consistent with the Centers for Medicare & Medicaid Services (CMS) protocols established under 42 CFR §438.352.[1-3]

1-1 U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Oct 28, 2021.

1-2 U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1340. Accessed on: Oct 28, 2021.

1-3 U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1352. Accessed on: Oct 28, 2021.

During the 2021–2022 contract year, and consistent with the applicable CMS protocols, HSAG performed the following EQR activities and provided to AHS and the **Department of Vermont Health Access** (**DVHA**) draft and final reports for each activity:

- Validated **DVHA**'s performance improvement project (PIP)
- Validated a set of **DVHA**'s performance measures
- Reviewed **DVHA**'s compliance with the federal Medicaid managed care standards described at 42 CFR §438.236, §438.242, and §438.330, and the related AHS/**DVHA** intergovernmental agreement (IGA) (i.e., contract) requirements
- Prepared this annual EQR technical report

Purpose

Under its federal Medicaid demonstration waiver, the State of Vermont uses a managed care model to deliver services and is subject to the Medicaid Managed Care standards/regulations found at 42 CFR §438. This report meets the federal requirement (42 CFR §438.364)[1-4] for preparation of an annual technical report that describes how data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and the access to, care furnished by **DVHA**, the single, statewide Medicaid PIHP/managed care entity (MCE) in the State of Vermont.

The report also includes HSAG's assessment of **DVHA**'s strengths and, as applicable, improvement recommendations in response to less than fully compliant performance and suggestions for **DVHA** to consider in further enhancing its processes, documentation, and/or performance results in providing quality, timely, and accessible care and services to its beneficiaries. Finally, the report describes **DVHA**'s self-reported improvement actions taken, still in progress, or planned in response to HSAG's prior year recommendations for each of the three activities HSAG conducted (review of compliance with standards, validation of **DVHA**'s PIP, and validation of **DVHA**'s performance measures).

Organization of the Report

DVHA, in the documentation provided to HSAG for the review, and HSAG in this report used the terms "enrollee," "member," and "beneficiary" interchangeably to designate the individuals enrolled in **DVHA** and receiving the applicable Medicaid managed care services.

[1-4] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML%23se42.4.438_1352#se42.4.438_1364. Accessed on: Oct 28, 2021.

Section 1—Introduction and Summary of Findings: Section 1 outlines the purpose and organization of the report. This section also describes the methodology HSAG used to develop the EQR annual technical report, to categorize the results, and to draw conclusions regarding **DVHA**'s performance results related to each EQR activity.

Section 2—Detailed Findings: This section provides contextual information about the federal Medicaid managed care requirements, AHS, and **DVHA**. This section also presents a summary of findings and conclusions about **DVHA**'s strengths and weaknesses, as derived from the EQR activities performed during 2021–2022. Section 2 also includes recommendations and opportunities for **DVHA** to improve quality, timeliness, and access to care. Finally, HSAG presents trends over time as appropriate to the data available.

Section 3—EQR Assessment of DVHA's Strengths and Weaknesses and Summary of Quality, Timeliness, and Access: This section describes **DVHA**'s strengths and weaknesses, as identified through the EQR activities performed during 2021–2022. Section 3 also includes a summary of conclusions related to the quality, timeliness, and accessibility of care provided to beneficiaries.

Section 4—Assessment of Vermont's Quality Strategy: This section presents HSAG's review of the Vermont AHS Comprehensive Quality Strategy and describes how the State can target goals and objectives to better support improvement in the quality, timeliness, and accessibility of health care services. The information also offers conclusions and recommendations pertaining to continuous improvement in the quality, timeliness, and accessibility of care provided to beneficiaries.

Section 5—Description of External Quality Review Activities: For each activity HSAG performed, Section 3 provides information related to the objectives of the activity, a description of the data obtained, technical methods of data collection and analysis, and a description of how overall conclusions were drawn related to **DVHA**'s performance.

Section 6—Follow-Up on Prior Year Recommendations: This section presents **DVHA**'s self-reported information concerning the improvement actions the organization took in response to the recommendations HSAG made in the previous year's EQR report. The section also includes the extent to which **DVHA** was successful in improving its performance results.

Opportunities for Improvement

Table 1-1 contains a list of the opportunities for improvement for **DVHA** that includes all EQR tasks described in this 2021–2022 EQR Technical Report. The table includes contract compliance standards that did not achieve a score of 100 percent and Healthcare Effectiveness Data and Information Set (HEDIS®)[1-5] measures that did not achieve a rate above the Medicaid 50th percentile. Vermont used the 50th percentile national benchmarks for HEDIS® measures used to monitor performance in the areas of access and quality. Additional information about the tasks displayed in Table 1-1 is included in the Detailed Findings section of this report.

Table 1-1—Opportunities for Improvement for DVHA

EQR Activity	Measure Standard	MCO Results	Standard
Contract Compliance Review	II. Quality Assessment and Performance Improvement (QAPI) Program	90.0%	100%
HEDIS	*Adults' Access to Preventive/Ambulatory Health Services—45–64 Years and 65+ Years*	Below the Medicaid 25th percentile	At or Above the Medicaid 50th Percentile
	Breast Cancer Screening	Below the Medicaid 25th percentile	At or Above the Medicaid 50th Percentile
	Chlamydia Screening in Women—16–20 Years, 21–24, and Total	Below the Medicaid 25th percentile	At or Above the Medicaid 50th Percentile
	*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years***	Below the Medicaid 25th percentile	At or Above the Medicaid 50th Percentile
	*Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years***	Below the Medicaid 25th percentile	At or Above the Medicaid 50th Percentile
	*Initiation and Engagement of Alcohol or Other Drug (AOD) Abuse or Dependence Treatment (Initiation)—13–17 Years—Total**	Below the Medicaid 25th percentile	At or Above the Medicaid 50th Percentile
	*Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—65+ Years***	Below the Medicaid 25th percentile	At or Above the Medicaid 50th Percentile

[1-5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

EQR Activity	Measure Standard	MCO Results	Standard
	*Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—65+ Years***	Below the Medicaid 25th percentile	At or Above the Medicaid 50th Percentile
	*Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—13–17 Years***	Below the Medicaid 25th percentile	At or Above the Medicaid 50th Percentile
	*Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—13–17 Years***	Below the Medicaid 25th percentile	At or Above the Medicaid 50th Percentile
	*Comprehensive Diabetes Care—Poor HbA1c Control***	Below the Medicaid 25th percentile	At or Above the Medicaid 50th Percentile

* Indicates that the indicator scored below the 10th percentile.
** Indicates that the indicator scored below the 5th percentile.

2. Detailed Findings

Background

The BBA, Public Law 105-33,[2-1] and as described in 42 CFR §438.364, requires state Medicaid agencies to contract with an EQRO to prepare an annual report that describes the manner in which data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed.[2-2] The report also must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the Medicaid MCOs, PIHPs, PAHPs, and PCCM entities. AHS chose to meet this requirement by contracting with HSAG, an EQRO, beginning in contract year 2007–2008 to conduct the three CMS required activities and to prepare an EQR annual technical report that includes the results from the activities it conducted. This report meets the requirements of 42 CFR §438.364 and does not disclose the identity or other PHI of any beneficiary.

The Vermont Agency of Human Services (AHS)

AHS is the State agency responsible for administrating the Medicaid managed care program in Vermont. In fall 2005, the Vermont Legislature approved implementation of the Global Commitment to Health Waiver, a demonstration initiative operated under an 1115 waiver. The waiver allowed the State to designate the Office of Vermont Health Access (OVHA), now **DVHA**, as the first statewide public managed care model organization. Subsequently, through a restructuring of the AHS, the organization became an AHS department. While a department of the State, **DVHA**'s role, responsibility, and funding are equivalent to that of other state Medicaid agencies' contracted MCOs. **DVHA** has written IGAs with other AHS departments to which it delegates certain administrative functions and the provision of direct services; contracts with community-based service providers; and contracts with entities to which it delegates certain administrative functions (e.g., beneficiary services and pharmacy benefit management services).

During the current EQR contract year (February 2021–December 31, 2021), HSAG conducted three mandatory EQR activities and compared the information to **DVHA**'s performance data from the prior year. This 2021–2022 EQR technical report contains the results of HSAG's review.

As stated, in part, in its Strategic Plan, AHS strives to improve the health and well-being of Vermonters. AHS' vision includes the assurance of high-quality health care for all Vermonters. In referring to "health," AHS includes physical health, mental health, and health in the area of substance abuse.

2-1 U. S. Government Publishing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: Nov 5, 2021.

2-2 U. S. Government Publishing Office. (2017). *External Quality Review Results.* Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1a64dceea153294481f0d7b923980163&mc=true&node=se42.4.438_1364&rgn=div8. Accessed on: Nov 5, 2021.

The State of Vermont's leadership, from the governor down, and AHS continue to be recognized nationally as well as by HSAG:

- As proactive leaders and innovators in designing and implementing health care reforms, implementing creative and effective health care delivery and financing models, and for their effective quality improvement and cost saving initiatives.
- For their collaboration relationships with other states to maximize and share tangible and intellectual resources, experiences, and best practices in designing and implementing creative, effective, and cost-efficient changes. The State's and its multistate health care partners are frequently featured and highlighted in national literature, health care reports, and media for their:
  - Visionary models and initiatives.
  - Collaborative, innovative, and inclusive approach to building stronger, more effective and cost-efficient models for delivering care.

The Department of Vermont Health Access

DVHA is the State department responsible for the management of Medicaid, the Vermont Children's Health Insurance Program (CHIP), and other publicly funded health insurance programs in Vermont. It is also responsible for (1) state oversight and coordination of Vermont's expansive Health Care Reform initiatives which are designed to increase access, improve quality, and contain the cost of health care for all Vermonters; (2) Vermont's health information technology strategic planning, coordination, and oversight; and (3) the Blueprint for Health.

DVHA's stated mission as the statewide Medicaid managed care model organization is to protect and promote the best health for all Vermonters through:

- Effective and integrated public health programs;
- Communities with the capacity to respond to public health needs;
- Internal systems that provide consistent and responsive support;
- A competent and valued workforce that is supported in promoting and protecting the public's health;
- A public health system that is understood and valued by Vermonters; and
- Health equity for all Vermonters.

Scope of HSAG's 2021–2022 EQR Activities

HSAG's EQR activities in contract year 2021–2022 consisted of conducting the following:

- ***Validation of DVHA's performance improvement project (PIP).*** HSAG reviewed **DVHA**'s PIP to ensure that the organization designed, conducted, and reported on the project in a methodologically sound manner, allowing measurement of any real improvements in care and services, and giving confidence in the reported improvements.
- ***Validation of DVHA's performance measures.*** HSAG validated the accuracy of the AHS-required performance measures that were reported by **DVHA**. The validation also determined the extent to which the Medicaid-specific performance measures calculated by **DVHA** followed the HEDIS 2021 specifications.
- ***Review of DVHA's compliance with standards.*** HSAG conducted a review to determine the organization's compliance with performance standards (sets of requirements) described in the federal Medicaid managed care regulations described at 42 CFR §438.236 (Practice Guidelines), §438.242 (Health Information Systems), and §438.330 (Quality Assessment and Performance Improvement [QAPI] Program) and with the associated requirements contained in the AHS IGA (i.e., contract) with **DVHA**.
- ***Preparation of the external quality review annual technical report.*** HSAG compiled and analyzed all data from its 2021–2022 EQR activities and drew conclusions related to the quality and timeliness of, and access to, care and services **DVHA** furnished to its Medicaid beneficiaries. This report describes the results of that process.

Summary of Findings

The following sections summarize HSAG's findings for each of the three activities conducted during 2021–2022.

Validation of the Performance Improvement Project (PIP)

HSAG validated **DVHA**'s new PIP, *Managing Hypertension.* HSAG used the U.S. Department of Health and Human Services (DHHS) CMS' *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[2-3] as the methodology to validate the PIP. HSAG's validation assessed Steps 1 through 6.

The PIP topic addresses the management and control of hypertension and is based on the HEDIS 2021 *Controlling High Blood Pressure (CBP)* measure and technical specifications. The topic was selected after collection and analysis of data and an environmental scan for measure alignment and priority. The

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1: Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related activity,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 5, 2021.

target population is Vermont Medicaid members 18 to 85 years of age who have a diagnosis of hypertension and whose blood pressure is adequately controlled (<140/90 mm Hg).

DVHA's *Managing Hypertension* PIP received a score of 100 percent for all applicable evaluation elements scored as *Met*, a score of 100 percent for critical evaluation elements scored as *Met*, and an overall validation status of *Met*, as displayed in Table 2-1.

Table 2-1—2021 PIP Validation Summary Overall Score

Percentage Score of Evaluation Elements *Met**	**100%**
Percentage Score of Critical Elements *Met***	**100%**
Validation Status	***Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

Table 2-2 displays **DVHA**'s performance across all PIP steps. The third column represents the total number of evaluation elements *Met* compared to the total number of applicable evaluation elements for each activity reviewed, including critical elements.

Table 2-2—Performance Across All Activities

Stage	Step	Percentage of Applicable Elements		
		Met	***Partially Met***	***Not Met***
Design	1. Review the selected PIP Topic	100% (2/2)	0% (0/2)	0% (0/2)
	2. Review the PIP Aim Statement	100% (1/1)	0% (0/1)	0% (0/1)
	3. Review the Identified PIP Population	100% (1/1)	0% (0/1)	0% (0/1)
	4. Review the Sampling Method	100% (7/7)	0% (0/7)	0% (0/7)
	5. Review the Selected Performance Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	6. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (15/15)**	**0% (0/15)**	**0% (0/15)**

Stage	Step	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Implementation*	7. Review Data analysis and Interpretation of Results	Not Assessed		
	8. Assess the Improvement	Not Assessed		
Implementation Total		**Not Assessed**		
Outcomes	9. Assess for Significant and Sustained Improvement	Not Assessed		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (15/15)**		

* Conclusions related to the PIP will be formulated after completing the Implementation phase of the PIP, Steps 7 and 8, upon reporting of data or testing and implementation of interventions.

The validation results indicate an overall score of 100 percent across all applicable evaluation elements. **DVHA** initiated the PIP this year and developed the methodology (Design stage). The PIP will progress to the Implementation phase during the next fiscal year; in the Design stage of the PIP, however, no results will be generated for the study and no interventions will be tested.

Validation of Performance Measures

HSAG validated a set of performance measures selected by AHS that were calculated and reported by **DVHA**. The methodology HSAG used to validate the performance measures was based on CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[2-4] The validation findings confirmed that all rates were reportable. Table 2-3 displays the HEDIS measurement year (MY) 2019 and HEDIS MY 2020 performance measure results; the denominator for each measure (i.e., number [N]); and the change for each measure rate from HEDIS MY 2019 to HEDIS MY 2020. Please note that for measures reported using the administrative methodology, the denominator is the eligible population. Additionally, HSAG compared the measure results for HEDIS MY 2020 to the NCQA's HEDIS Audit Means and Percentiles National Medicaid Health Maintenance Organization (HMO) Percentiles (referred to as "percentiles" in this report) for HEDIS MY 2019 (the most current rates available).

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Sep 21, 2021.

Table 2-3—DVHA HEDIS MY 2019 and MY 2020 Results

Measure	HEDIS MY 2019		HEDIS MY 2020		Change From HEDIS MY 2019 to HEDIS MY 2020	HEDIS MY 2020 Percentile Rank
	N	Rate	N	Rate		
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	32,793	81.22%	39,397	76.25%	-4.97%	25th–50th
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	19,101	86.80%	21,350	82.48%	-4.32%	10th–25th
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	170	92.35%	298	83.22%	-9.13%	10th–25th
Adults' Access to Preventive/Ambulatory Health Services—Total	52,064	83.30%	61,045	78.46%	-4.84%	25th–50th
Child and Adolescent Well-Care Visits—3–11 Years	—	—	28,846	62.61%	NC	NC
Child and Adolescent Well-Care Visits—12–17 Years	—	—	18,849	54.56%	NC	NC
Child and Adolescent Well-Care Visits—18–21 Years	—	—	8,704	28.64%	NC	NC
Child and Adolescent Well-Care Visits—Total	—	—	56,399	54.68%	NC	NC
Breast Cancer Screening[2]	5,461	52.33%	5,796	48.57%	-3.76%	10th–25th
Chlamydia Screening in Women—16–20 Years	3,590	48.75%	3,821	41.48%	-7.27%	10th–25th
Chlamydia Screening in Women—21–24 Years	2,014	60.53%	2,289	54.78%	-5.75%	10th–25th
Chlamydia Screening in Women—Total	5,604	52.98%	6,110	46.46%	-6.52%	10th–25th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years[2]	291	46.74%	239	56.90%	+10.16%	75th–90th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years[2]	1,137	36.68%	873	41.81%	+5.13%	75th–90th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years[2]	0	NA	0	NA	NC	<5th
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total[2]	1,428	38.73%	1,112	45.05%	+6.32%	75th–90th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years[2]	291	72.16%	239	75.31%	+3.15%	50th–75th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years[2]	1,137	57.52%	873	61.86%	+4.34%	75th–90th

Measure	HEDIS MY 2019		HEDIS MY 2020		Change From HEDIS MY 2019 to HEDIS MY 2020	HEDIS MY 2020 Percentile Rank
	N	Rate	N	Rate		
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years[2]	0	NA	0	NA	NC	<5th
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total[2]	1,428	60.50%	1,112	64.75%	+4.25%	50th–75th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total[2]	198	30.30%	156	27.56%	-2.74%	5th–10th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total[2]	3,638	43.93%	3,365	45.85%	+1.92%	50th–75th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total—Total[2]	3,836	43.22%	3,521	45.04%	+1.82%	50th–75th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total[2]	198	15.66%	156	10.26%	-5.40%	25th–50th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—18+ Years—Total[2]	3,638	22.51%	3,365	23.18%	+0.67%	75th–90th
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total—Total[2]	3,836	22.16%	3,521	22.61%	+0.45%	75th–90th
Ambulatory Care (Outpatient Visits)—<1 Year[†,1]	33,738	990.17	27,574	840.31	-149.86	50th–75th
Ambulatory Care (Outpatient Visits)—1–9 Years[†,1]	109,270	311.15	80,620	229.64	-81.51	10th–25th
Ambulatory Care (Outpatient Visits)—10–19 Years[†,1]	89,407	246.33	72,810	194.72	-51.61	10th–25th
Ambulatory Care (Outpatient Visits)—20–44 Years[†,1]	155,975	287.07	144,174	248.35	-38.72	10th–25th
Ambulatory Care (Outpatient Visits)—45–64 Years[†,1]	171,725	485.91	154,602	420.28	-65.63	5th–10th
Ambulatory Care (Outpatient Visits)—65–74 Years[†,1]	41,060	687.00	36,923	565.75	-121.25	25th–50th
Ambulatory Care (Outpatient Visits)—75–84 Years[†,1]	21,085	690.00	18,346	577.12	-112.88	25th–50th

Measure	HEDIS MY 2019		HEDIS MY 2020		Change From HEDIS MY 2019 to HEDIS MY 2020	HEDIS MY 2020 Percentile Rank
	N	Rate	N	Rate		
Ambulatory Care (Outpatient Visits)—85+ Years[†,1]	10,604	517.87	9,181	454.37	-63.50	25th–50th
Ambulatory Care (Outpatient Visits)—Total[†,1]	632,864	360.45	544,230	298.46	-61.99	10th–25th
*Ambulatory Care (Emergency Department [ED] Visits)—<1 Year**[,1]	2,407	70.64	1,400	42.66	-27.98	≥95th
*Ambulatory Care (ED Visits)—1–9 Years**[,1]	12,702	36.17	7,581	21.59	-14.58	≥95th
*Ambulatory Care (ED Visits)—10–19 Years**[,1]	13,028	35.89	9,353	25.01	-10.88	90th–95th
*Ambulatory Care (ED Visits)—20–44 Years**[,1]	33,982	62.54	27,672	47.67	-14.87	90th–95th
*Ambulatory Care (ED Visits)—45–64 Years**[,1]	20,255	57.31	16,535	44.95	-12.36	90th–95th
*Ambulatory Care (ED Visits)—65–74 Years**[,1]	3,796	63.51	3,523	53.98	-9.53	25th–50th
*Ambulatory Care (ED Visits)—75–84 Years**[,1]	1,989	65.09	1,548	48.70	-16.39	25th–50th
*Ambulatory Care (ED Visits)—85+ Years**[,1]	1,021	49.86	810	40.09	-9.77	25th–50th
*Ambulatory Care (ED Visits)—Total**[,1]	89,180	50.79	68,422	37.52	-13.27	90th–95th
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	2,607	70.35%	NC	NC
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Ages 15 to 30 Months—Two or More Well-Child Visits	—	—	2,572	83.32%	NC	NC
Asthma Medication Ratio—5–11 Years	—	—	511	74.95%	NC	50th–75th
Asthma Medication Ratio—12–18 Years	—	—	445	65.17%	NC	25th–50th
Asthma Medication Ratio—19–50 Years	—	—	1,199	49.96%	NC	25th–50th
Asthma Medication Ratio—51–64 Years	—	—	340	60.88%	NC	75th–90th
Asthma Medication Ratio—Total	—	—	2,495	59.28%	NC	25th–50th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years[2]	429	89.04%	284	88.73%	-0.31%	≥95th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—18–64 Years[2]	705	67.23%	653	63.09%	-4.14%	75th–90th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—65+ Years[2]	0	NA	0	NA	NC	<5th
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total[2]	1,134	75.49%	937	70.86%	-4.63%	90th–95th

Measure	HEDIS MY 2019		HEDIS MY 2020		Change From HEDIS MY 2019 to HEDIS MY 2020	HEDIS MY 2020 Percentile Rank
	N	Rate	N	Rate		
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years[2]	429	91.84%	284	91.90%	+0.06%	≥95th
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—18–64 Years[2]	705	75.60%	653	71.67%	-3.93%	75th–90th
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—65+ Years[2]	0	NA	0	NA	NC	<5th
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total[2]	1,134	81.75%	937	77.80%	-3.95%	90th–95th
Follow-Up After ED Visit for Alcohol or Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—13–17 Years[2]	34	14.71%	28	NA	NC	<5th
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—18+ Years[2]	1,149	24.54%	1,054	22.30%	-2.24%	75th–90th
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total[2]	1,183	24.26%	1,082	21.90%	-2.36%	75th–90th
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—13–17 Years[2]	34	23.53%	28	NA	NC	<5th
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—18+ Years[2]	1,149	36.55%	1,054	33.11%	-3.44%	75th–90th
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total[2]	1,183	36.18%	1,082	32.53%	-3.65%	75th–90th
Developmental Screening in the First Three Years of Life—1 Year	2,649	49.83%	2,578	43.52%	-6.31%	NC
Developmental Screening in the First Three Years of Life—2 Years	2,762	62.13%	2,651	57.56%	-4.57%	NC
Developmental Screening in the First Three Years of Life—3 Years	2,884	59.78%	2,840	57.61%	-2.17%	NC
Developmental Screening in the First Three Years of Life—Total	8,295	57.38%	8,069	53.09%	-4.29%	NC
Prenatal and Postpartum Care—Timeliness of Prenatal Care[2]	411	69.59%	411	84.67%	+15.08%	25th–50th
Prenatal and Postpartum Care—Postpartum Care[2]	411	65.45%	411	77.37%	+11.92%	50th–75th

Measure	HEDIS MY 2019		HEDIS MY 2020		Change From HEDIS MY 2019 to HEDIS MY 2020	HEDIS MY 2020 Percentile Rank
	N	Rate	N	Rate		
Controlling High Blood Pressure	—	—	411	42.58%	NC	NC
Comprehensive Diabetes Care—Poor HbA1c Control†,[2]	—	—	411	54.01%	NC	<5th

* For this indicator, a lower rate indicates better performance.
† Rates for this indicator are presented for information only.
[1] For the Ambulatory Care indicators, N represents the number of visits instead of the denominator, and the rates displayed are the number of visits per 1,000 member months.
[2] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2020 and prior years be considered with caution.
— indicates that NCQA recommended a break in trending or the measure is a first-year measure for HEDIS MY 2020; therefore, prior year rates are not displayed.
NA indicates that a rate could not be reported due to a small denominator.
NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS MY 2020 is the first year this measure is being reported.

Excluding information-only measures, **DVHA** demonstrated strength, with 10 measure rates meeting or exceeding the 90th percentile. Of the 53 reportable rates with comparable benchmarks, four rates met or exceeded the 95th percentile:

- *Ambulatory Care (ED Visits)—<1 Year*
- *Ambulatory Care (ED Visits)—1–9 Years*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years*

Six rates met or exceeded the 90th percentile but were below the 95th percentile:

- *Ambulatory Care (ED Visits)—10–19 Years*
- *Ambulatory Care (ED Visits)—20–44 Years*
- *Ambulatory Care (ED Visits)—45–64 Years*
- *Ambulatory Care (ED Visits)—Total*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total*

DVHA demonstrated opportunities for improvement, with the following 14 rates falling below the 25th percentile:

- *Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*

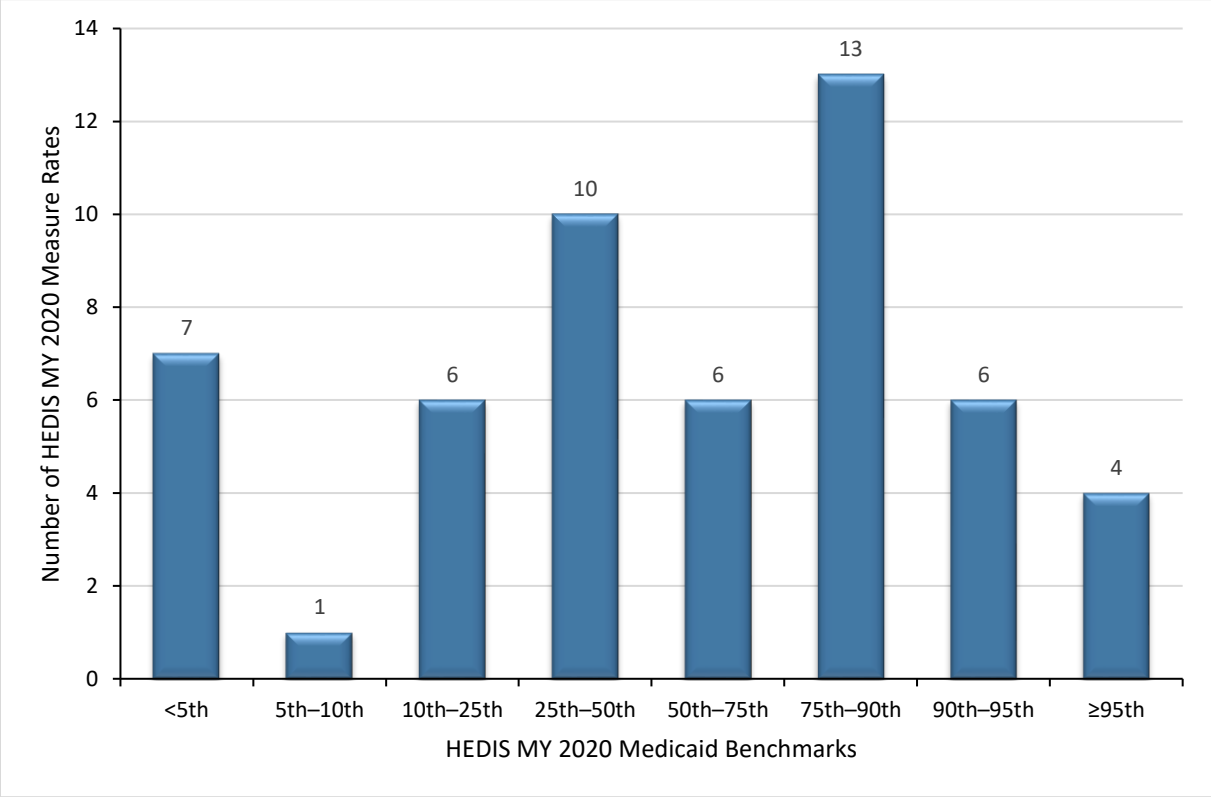
- *Adults' Access to Preventive/Ambulatory Health Services—65+ Years*
- *Breast Cancer Screening*
- *Chlamydia Screening in Women—16–20 Years*
- *Chlamydia Screening in Women—21–24 Years*
- *Chlamydia Screening in Women—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—65+ Years*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—65+ Years*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—13–17 Years*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—13–17 Years*
- *Comprehensive Diabetes Care—Poor HbA1c Control*

An additional 10 rates fell below the 50th percentile but were at or above the 25th percentile:

- *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total*
- *Ambulatory Care (ED Visits)—65–74 Years*
- *Ambulatory Care (ED Visits)—75–84 Years*
- *Ambulatory Care (ED Visits)—85+ Years*
- *Asthma Medication Ratio—12–18 Years*
- *Asthma Medication Ratio—19–50 Years*
- *Asthma Medication Ratio—Total*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Figure 2-1 shows the distribution of how the reported indicators compared to the HEDIS MY 2020 national Medicaid benchmarks.

Figure 2-1—Number of HEDIS MY 2020 Measure Rates Meeting the HEDIS MY 2019 Medicaid Benchmarks



DVHA performed at or above the 75th percentile for 23 of 53 (43.4 percent) measure rates appropriate for comparison to benchmarks, demonstrating strengths in sufficient follow-up care following ED visits for mental illness and AOD abuse dependence, appropriate ambulatory care (ED utilization), and engagement of AOD abuse or dependence treatment. Conversely, 24 of 53 rates (45.3 percent) fell below the 50th percentile, indicating efforts should be focused on ensuring adults have access to preventive and ambulatory care services, ED ambulatory care, and prenatal care. **DVHA** also should focus on educating members on the importance of preventive care screenings. Initiation of AOD abuse or dependence treatment and controlling high blood pressure are additional areas of focus for **DVHA**.

Review of Compliance With Standards

AHS requested that HSAG continue to review one of the three sets of federal Medicaid managed care standards during each EQR contract year. For EQR contract year 2021–2022, AHS requested that HSAG conduct a review of the federal Medicaid managed care standards described at 42 CFR §438.236 (Practice Guidelines), §438.242 (Health Information Systems), and §438.330 (QAPI Program), and the related AHS/**DVHA** IGA (i.e., contract) requirements.

HSAG conducted the review consistent with CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[2-5] HSAG reviewed **DVHA**'s written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to **DVHA**'s performance during the review period. Reviewers also conducted staff interviews related to each of the three standards to allow **DVHA** staff members to elaborate on the written information HSAG reviewed, to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any questions reviewers had following the document review.

The primary objective of HSAG's review was to identify and provide meaningful information to AHS and **DVHA** about **DVHA**'s performance strengths and any areas requiring corrective actions. The information included HSAG's report of its findings related to the extent to which **DVHA**'s performance complied with the applicable federal Medicaid managed care regulations and AHS' associated IGA contract requirements for providing accessible, timely, and quality services to beneficiaries.

Table 2-4 presents a summary of **DVHA**'s performance results for the three standard areas reviewed. The information includes:

- The total number of elements (i.e., requirements) and the number of applicable elements for each of the standards.
- The number of elements for each of the standards that received a score of *Met*, *Partially Met*, *Not Met*, or a designation of NA (not applicable), as well as the totals across the three standards.
- The total compliance score for each of the standards.
- The overall compliance score across all standards.

Table 2-4—Standards and Compliance Score

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Practice Guidelines	8	8	8	0	0	0	**100%**
II	Quality Assessment and Performance Improvement (QAPI) Program	10	10	8	2	0	0	**90%**
III	Health Information Systems	6	6	6	0	0	0	**100%**
	Totals	**24**	**24**	**22**	**2**	**0**	**0**	**95.8%**

***Total # of Elements*:** The total number of elements in each standard.
***Total # of Applicable Elements*:** The total number of elements within each standard minus any elements that received a score of *NA*.
***Total Compliance Score*:** The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted number (multiplied by 0.50) that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

[2-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 5, 2021.

As displayed in Table 2-4, HSAG reviewed **DVHA**'s performance related to 24 elements across the three standards. Of the 24 elements, **DVHA** obtained a score of *Met* for 22 elements (91.6 percent) and a *Partially Met* score for two elements (8.3 percent). As a result, **DVHA** obtained a total percentage-of-compliance score across the 24 elements of 95.8 percent.

Overall Conclusions and Performance Trending

Performance Trends

Performance Improvement Project Trends

DVHA initiated a new PIP topic, *Managing Hypertension*, in contract year 2021–2022. **DVHA** performed well in meeting the requirements in the Design stage of the PIP, achieving all validation criteria in Steps 1 through 6. HSAG determined that **DVHA** designed a methodologically sound improvement project. The technical design of the PIP was valid to measure reliable performance indicator outcomes. The PIP had not progressed to reporting data, testing, or implementing interventions (Steps 7–8); therefore, no conclusions could be drawn related to the PIP. Baseline data and quality improvement processes and strategies will be reported in the next annual EQR technical report.

Table 2-5 outlines the performance indicator for the PIP.

Table 2-5—*Managing Hypertension* PIP Performance Indicator

PIP Title	Performance Indicator
Managing Hypertension	The percentage of Vermont Medicaid members 18 to 85 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).

Table 2-6—*Managing Hypertension* PIP for Department of Vermont Health Access

PIP—Managing Hypertension			
Performance Indicator	**Baseline (1/1/2021—12/31/2021)**	**Remeasurement 1 (1/1/2022–12/31/2022)**	**Remeasurement 2 (1/1/2023–12/31/2023)**
The percentage of Vermont Medicaid members 18 to 85 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).	TBD	TBD	TBD

Performance Measure Trends

DVHA used a vendor with HEDIS Certified Measures[SM, 2-6] to calculate and report the HEDIS MY 2020 performance measure rates. Table 2-7 below displays the rates for measures **DVHA** reported for HEDIS MY 2017, MY 2018, MY 2019 and MY 2020; the denominator (i.e., N); and the change for each measure rate from HEDIS MY 2017 to HEDIS MY 2020.

Table 2-7—HEDIS MY 2017, MY 2018, MY 2019, and MY 2020 Results

Measure	HEDIS MY 2017		HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		Change From HEDIS MY 2017 to HEDIS MY 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	37,645	79.39%	37,112	79.40%	32,793	81.22%	39,397	76.25%	-3.14%
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	21,594	85.22%	20,960	85.61%	19,101	86.80%	21,350	82.48%	-2.74%
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	427	82.44%	381	79.27%	170	92.35%	298	83.22%	+0.78%
Adults' Access to Preventive/Ambulatory Health Services—Total	59,666	81.52%	58,453	81.63%	52,064	83.30%	61,045	78.46%	-3.06%
Child and Adolescent Well-Care Visits—3–11 Years	—	—	—	—	—	—	28,846	62.61%	NC
Child and Adolescent Well-Care Visits—12–17 Years	—	—	—	—	—	—	18,849	54.56%	NC
Child and Adolescent Well-Care Visits—18–21 Years	—	—	—	—	—	—	8,704	28.64%	NC
Child and Adolescent Well-Care Visits—Total	—	—	—	—	—	—	56,399	54.68%	NC
Breast Cancer Screening[2]	6,189	54.26%	5,885	52.90%	5,461	52.33%	5,796	48.57%	-5.69%
Chlamydia Screening in Women—16–20 Years	4,003	49.74%	3,899	50.83%	3,590	48.75%	3,821	41.48%	-8.26%
Chlamydia Screening in Women—21–24 Years	2,575	58.06%	2,347	59.65%	2,014	60.53%	2,289	54.78%	-3.28%
Chlamydia Screening in Women—Total	6,578	52.99%	6,246	54.15%	5,604	52.98%	6,110	46.46%	-6.53%

2-6 HEDIS Certified Measures[SM] is a service mark of the NCQA.

Measure	HEDIS MY 2017		HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		Change From HEDIS MY 2017 to HEDIS MY 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years[2]	—	—	326	45.40%	291	46.74%	239	56.90%	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years[2]	—	—	1,207	32.56%	1,137	36.68%	873	41.81%	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years[2]	—	—	0	NA	0	NA	0	NA	NC
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total[2]	1,324	33.91%	1,533	35.29%	1,428	38.73%	1,112	45.05%	+11.14%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years[2]	—	—	326	68.10%	291	72.16%	239	75.31%	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years[2]	—	—	1,207	46.81%	1,137	57.52%	873	61.86%	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years[2]	—	—	0	NA	0	NA	0	NA	NC
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total[2]	1,324	52.72%	1,533	51.34%	1,428	60.50%	1,112	64.75%	+12.03%
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—13–17 Years—Total[2]	235	35.74%	214	35.98%	198	30.30%	156	27.56%	-8.18%
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—18+ Years—Total[2]	4,378	38.21%	4,038	39.80%	3,638	43.93%	3,365	45.85%	+7.64%
Initiation and Engagement of AOD Abuse or Dependence Treatment (Initiation)—Total—Total[2]	4,613	38.09%	4,252	39.60%	3,836	43.22%	3,521	45.04%	+6.95%

Measure	HEDIS MY 2017		HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		Change From HEDIS MY 2017 to HEDIS MY 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—13–17 Years—Total[2]	235	18.30%	214	15.89%	198	15.66%	156	10.26%	-8.04%
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—18+ Years—Total[2]	4,378	19.67%	4,038	18.70%	3,638	22.51%	3,365	23.18%	+3.51%
Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total—Total[2]	4,613	19.60%	4,252	18.56%	3,836	22.16%	3,521	22.61%	+3.01%
Ambulatory Care (Outpatient Visits)—<1 Year[†,1]	33,567	905.75	33,648	960.33	33,738	990.17	27,574	840.31	-65.44
Ambulatory Care (Outpatient Visits)—1–9 Years[†,1]	112,957	298.1	111,897	305.38	109,270	311.15	80,620	229.64	-68.46
Ambulatory Care (Outpatient Visits)—10–19 Years[†,1]	90,621	242.35	91,496	246.87	89,407	246.33	72,810	194.72	-47.63
Ambulatory Care (Outpatient Visits)—20–44 Years[†,1]	148,279	261.51	145,013	266.76	155,975	287.07	144,174	248.35	-13.16
Ambulatory Care (Outpatient Visits)—45–64 Years[†,1]	124,066	407.84	121,604	419.45	171,725	485.91	154,602	420.28	+12.44
Ambulatory Care (Outpatient Visits)—65–74 Years[†,1]	1,223	321.08	1,005	288.96	41,060	687.00	36,923	565.75	+244.67
Ambulatory Care (Outpatient Visits)—75–84 Years[†,1]	438	598.36	261	446.92	21,085	690.00	18,346	577.12	-21.24
Ambulatory Care (Outpatient Visits)—85+ Years[†,1]	231	596.9	89	NA	10,604	517.87	9,181	454.37	-142.53
Ambulatory Care (Outpatient Visits)—Total[†,1]	511,382	306.94	505,013	313.68	632,864	360.45	544,230	298.46	-8.48
*Ambulatory Care (Emergency Department [ED] Visits)—<1 Year**[*,1]	2,320	62.6	2,326	66.39	2,407	70.64	1,400	42.66	-19.94
*Ambulatory Care (ED Visits)—1–9 Years**[*,1]	13,438	35.46	13,069	35.67	12,702	36.17	7,581	21.59	-13.87
*Ambulatory Care (ED Visits)—10–19 Years**[*,1]	13,539	36.21	13,176	35.55	13,028	35.89	9,353	25.01	-11.20

Measure	HEDIS MY 2017		HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		Change From HEDIS MY 2017 to HEDIS MY 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Ambulatory Care (ED Visits)—20–44 Years,[1]*	32,773	57.8	31,829	58.55	33,982	62.54	27,672	47.67	-10.13
Ambulatory Care (ED Visits)—45–64 Years,[1]*	12,962	42.61	12,828	44.25	20,255	57.31	16,535	44.95	+2.34
Ambulatory Care (ED Visits)—65–74 Years,[1]*	77	20.22	56	16.10	3,796	63.51	3,523	53.98	+33.76
Ambulatory Care (ED Visits)—75–84 Years,[1]*	26	35.52	10	17.12	1,989	65.09	1,548	48.70	+13.18
Ambulatory Care (ED Visits)—85+ Years,[1]*	12	31.01	8	NA	1,021	49.86	810	40.09	+9.08
Ambulatory Care (ED Visits)—Total,[1]*	75,147	45.10	73,302	45.53	89,180	50.79	68,422	37.52	-7.58
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	—	—	—	—	2,607	70.35%	NC
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Ages 15 to 30 Months—Two or More Well-Child Visits	—	—	—	—	—	—	2,572	83.32%	NC
Asthma Medication Ratio—5–11 Years	—	—	—	—	—	—	511	74.95%	NC
Asthma Medication Ratio—12–18 Years	—	—	—	—	—	—	445	65.17%	NC
Asthma Medication Ratio—19–50 Years	—	—	—	—	—	—	1,199	49.96%	NC
Asthma Medication Ratio—51–64 Years	—	—	—	—	—	—	340	60.88%	NC
Asthma Medication Ratio—Total	—	—	—	—	—	—	2,495	59.28%	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—6–17 Years[2]	—	—	—	—	429	89.04%	284	88.73%	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—18–64 Years[2]	—	—	—	—	705	67.23%	653	63.09%	NC

Measure	HEDIS MY 2017		HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		Change From HEDIS MY 2017 to HEDIS MY 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—65+ Years[2]	—	—	—	—	0	NA	0	NA	NC
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total[2]	—	—	—	—	1,134	75.49%	937	70.86%	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—6–17 Years[2]	—	—	—	—	429	91.84%	284	91.90%	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—18–64 Years[2]	—	—	—	—	705	75.60%	653	71.67%	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—65+ Years[2]	—	—	—	—	0	NA	0	NA	NC
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total[2]	—	—	—	—	1,134	81.75%	937	77.80%	NC
Follow-Up After ED Visit for Alcohol or Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—13–17 Years[2]	—	—	—	—	34	14.71%	28	NA	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—18+ Years[2]	—	—	—	—	1,149	24.54%	1,054	22.30%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total[2]	—	—	—	—	1,183	24.26%	1,082	21.90%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—13–17 Years[2]	—	—	—	—	34	23.53%	28	NA	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—18+ Years[2]	—	—	—	—	1,149	36.55%	1,054	33.11%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total[2]	—	—	—	—	1,183	36.18%	1,082	32.53%	NC

Measure	HEDIS MY 2017		HEDIS MY 2018		HEDIS MY 2019		HEDIS MY 2020		Change From HEDIS MY 2017 to HEDIS MY 2020
	N	Rate	N	Rate	N	Rate	N	Rate	
Developmental Screening in the First Three Years of Life—1 Year	—	—	—	—	2,649	49.83%	2,578	43.52%	NC
Developmental Screening in the First Three Years of Life—2 Years	—	—	—	—	2,762	62.13%	2,651	57.56%	NC
Developmental Screening in the First Three Years of Life—3 Years	—	—	—	—	2,884	59.78%	2,840	57.61%	NC
Developmental Screening in the First Three Years of Life—Total	—	—	—	—	8,295	57.38%	8,069	53.09%	NC
Prenatal and Postpartum Care—Timeliness of Prenatal Care[2]	—	—	—	—	411	69.59%	411	84.67%	NC
Prenatal and Postpartum Care—Postpartum Care[2]	—	—	—	—	411	65.45%	411	77.37%	NC
Controlling High Blood Pressure	—	—	—	—	—	—	411	42.58%	NC
Comprehensive Diabetes Care—Poor HbA1c Control†,[2]	—	—	—	—	—	—	411	54.01%	NC

* For this indicator, a lower rate indicates better performance.

† Rates for this indicator are presented for information only.

[1] For the Ambulatory Care indicators, N represents the number of visits instead of the denominator, and the rates displayed are the number of visits per 1,000 member months.

[2] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2020 and prior years be considered with caution.

— indicates that NCQA recommended a break in trending or the measure is a first-year measure for HEDIS MY 2020; therefore, prior year rates are not displayed.

NA indicates that a rate could not be reported due to a small denominator.

NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS MY 2020 is the first year this measure is being reported.

Overall, 12 of the 25 (48 percent) measure rates that could be trended showed an improvement in performance since HEDIS MY 2017 (excluding information-only measures). The *Ambulatory Care (ED Visits)—<1 Year* rate improved by almost 20 percentage points, and the *Ambulatory Care (ED Visits)—1–9 Years*, *10–19 Years*, and *20–44 Years* rates all improved by more than 10 percentage points. *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* rates also improved by more than 10 percentage points from HEDIS MY 2017 to HEDIS MY 2020. Of the 13 measure rates that showed a decline in performance, the *Ambulatory Care (ED Visits)—65–74*

Years rate declined by more than 30 percentage points, and the *Ambulatory Care (ED Visits)—75–84 Year*s rate declined by more than 10 percentage points.

Compliance With Standards Trends

The 2021–2022 review was the second year of HSAG's three-year cycle of compliance reviews. Due to the travel restrictions and stay-at-home orders in many states in response to the coronavirus disease 2019 (COVID-19), AHS, HSAG, and **DVHA** agreed to perform this year's compliance review virtually. HSAG performed a desk review of **DVHA**'s documents, and the virtual review included reviewing additional documents and conducting interviews with key **DVHA** staff members. HSAG evaluated the degree to which **DVHA** complied with federal Medicaid managed care regulations and the associated AHS IGA in three performance categories (i.e., standards). The three standards (i.e., Practice Guidelines, QAPI Program, and Health Information Systems) included requirements associated with the federal Medicaid managed care standards found at 42 CFR §438.236, §438.242, and §438.330.

HSAG reviews a different set of standards to evaluate **DVHA**'s compliance with federal CMS Medicaid managed care regulations and the associated AHS/**DVHA** IGA requirements during each year within a three-year cycle of reviews. The number of standards reviewed each year varies, as does the focus of the review. The three-year cycle consists of the following standards:

- Year 1—Beneficiary Information (42 CFR §438.10); Enrollee Rights (42 CFR §438.100); Provider Selection, Confidentiality, Grievance and Appeal Systems, and Subcontractual Relationships and Delegation requirements (42 CFR §438.214–§438.230)
- Year 2—Practice Guidelines, Health Information Systems, and QAPI Program standards (42 CFR §438.236, §438.242, and §438.330)
- Year 3—Access (42 CFR §438.206, §438.207, §438.208, and §438.210); Emergency and Poststabilization Services (42 CFR §438.114); and Managed Care Enrollment and Disenrollment Requirements and Limitations (§438.54–§438.56)

For this year (2021–2022—the 14th year of review), HSAG evaluated the Practice Guidelines, Health Information Systems, and QAPI Program standards, the same standards it reviewed in 2009, 2012, 2015, and 2018.

Table 2-8 documents **DVHA**'s performance across 14 years of compliance reviews conducted by HSAG.

Table 2-8—Comparison/Trending of Scores Achieved During Compliance Reviews

Year of the Review	Year 1 Standards			Year 2 Standards			Year 3 Standards		
	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*
2008	90	84%	30%						
2009				29	98%	3%			
2010							76	97%	7%

Year of the Review	Year 1 Standards			Year 2 Standards			Year 3 Standards		
	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*
2011	89	90%	20%						
2012				30	100%	0%			
2013							71	99%	3%
2014	93	92%	15%						
2015				31	97%	3%			
2016							80	97%	6%
2017	84	90%	19%						
2018				33	100%	0%			
2019							68	86%	22%
2020	88	94%	11%						
2021				24	96%	4%			

* The percentage of requirements for which HSAG scored **DVHA**'s performance as either partially meeting or not meeting the requirement.

For the Practice Guidelines, QAPI Program, and Health Information Systems (Year 2) standards, the overall scores **DVHA** received across the five years ranged from 96 percent to 100 percent, with the overall corrective action percentages ranging from 0 percent to 4 percent. During the prior review, **DVHA** scored 100 percent across the three standards.

Recommendations and Opportunities for Improvement

Performance Improvement Project

DVHA demonstrated proficiency in designing a new PIP. The following are HSAG's recommendations to **DVHA** based on validation of **DVHA**'s new PIP:

- **DVHA** should use quality improvement tools such as causal/barrier analysis, key driver diagram, process mapping, and/or failure modes and effects analysis to determine and prioritize barriers, drivers, and/or weaknesses within processes. The use of these tools will help **DVHA** determine which interventions to test and implement.
- **DVHA** should develop active, innovative interventions that have the potential for impacting the performance indicator outcomes.
- **DVHA** should develop a process or plan to evaluate the effectiveness of each individual intervention.
- **DVHA** should use Plan-Do-Study-Act cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.

Performance Measures

HSAG offers the following recommendations related to improving **DVHA**'s performance rates of quality, timeliness, and access-related measures; data collection; and reporting processes:

- With 24 of 53 rates (45.3 percent) falling below the 50th percentile, **DVHA** should consider focusing efforts on ensuring that adults have **access** to preventive and ambulatory care services, ED ambulatory care, and prenatal care. **DVHA** also should focus on ensuring women are appropriately screened for chlamydia and breast cancer. Initiation of AOD abuse or dependence treatment and controlling high blood pressure are additional areas of focus for **DVHA**.
- **DVHA** should pursue all available data sources to supplement its claims capture. **DVHA** should continue to explore the use of Vermont's clinical repository operated by Vermont Information Technology Leaders (VITL). VITL could potentially be an untapped resource for capturing supplemental data for measures.
- HSAG's recommendation remains from prior years as it did not appear that **DVHA** captured any data using Vermont's clinical repository. Capturing data from Vermont's clinical repository could help improve the **quality** and **timeliness** of, and **access** to care provided to beneficiaries.
- In addition, **DVHA** should continue its processes to monitor and trend claims submissions.

Compliance With Standards

HSAG offers the following recommendations related to improving **DVHA**'s compliance with standards:

- **DVHA** must ensure that the QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports (LTSS). The information should include an assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan. Implementing mechanisms to assess the care furnished to enrollees using LTSS could assist in identifying areas on which to focus efforts to improve the **quality** and **timeliness** of, and **access** to care provided to beneficiaries.
- **DVHA** must ensure that the QAPI program includes mechanisms to assess the appropriateness of care for members with special health care needs. Specifically, the treatment plan must identify specialist services that may be accessed directly by the beneficiary as appropriate for that beneficiary's condition and identified need. Such mechanisms could assist in identifying access issues and serve as an area on which to focus efforts to improve the **quality** and **timeliness** of, and **access** to care furnished to beneficiaries.

3. EQR Assessment of DVHA's Strengths and Weaknesses and Summary of Quality, Timeliness, and Access

The federal Medicaid managed care regulations require that "each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the care and services for which the organization is responsible."[3-1] CMS has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs, PIHPs, PAHPs, and PCCMs.

The following subsections include information concerning the objective of each activity included in this report, the technical methods of data collection and analysis, the description of data obtained, and how conclusions were drawn. The categorization of how HSAG formulated conclusions according to the quality, timeliness, or accessibility of care are based on the following definitions:

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through its (1) structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based knowledge, and (3) interventions for performance improvement.[3-2]

Timeliness

NCQA defines "timeliness" relative to utilization decisions as follows:

> "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3-3] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require a timely response by the managed care organization—e.g., processing expedited appeals and providing timely follow-up care.

3-1 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.* Available at: https://innovation.cms.gov/files/migrated-medicare-demonstration-x/cc_section4016_bba_1997.pdf. Accessed on: Nov 5, 2021.

3-2 Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 81, May 6, 2016.

3-3 National Committee for Quality Assurance. (2020). *Standards and Guidelines for Health Plans*.

Access

CMS defines "access" in the final rule at 42 CFR §438.320 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[3-4]

The CFR also requires that the EQR results include a description of how the data from all activities conducted in accordance with §438.358 were aggregated and analyzed and conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by the MCO, PIHP, PAHP, or PCCM entity in §438.364(a)(1).[3-5] HSAG follows a three-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each MCO as well as the program overall.

First, HSAG analyzes the quantitative results obtained from each EQR activity for each MCO to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of services furnished by the MCO for the EQR activity. Second, from the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain, and HSAG draws conclusions about the overall quality and timeliness of, and access to care and services furnished by the MCO. Lastly, HSAG identifies any patterns and commonalities that exist across the program to draw aggregated conclusions about the quality, timeliness, and accessibility of care for the program.

The following subsections of the report include the strengths and opportunities for improvement and provide an assessment and evaluation of the quality and timeliness of, and access to care and services for each MCO by task. That information is followed by a subsection which identifies common themes and patterns that emerged across the EQR activities for the MCO and includes conclusions about the quality and timeliness of, and access to care and services for the Vermont Medicaid beneficiaries.

Conclusions Related to Performance Improvement Project

To draw conclusions about the **quality** and **timeliness** of, and **access** to care **DVHA** provided, HSAG determined which components of the *Managing Hypertension* PIP activity could be used to assess these domains. Table 3-1 illustrates the **quality**, **timeliness**, and **access** domains related to the *Managing Hypertension* PIP.

Table 3-1—PIP Activity Components Assessing Quality, Timeliness, and Access

PIP	Quality	Timeliness	Access
Managing Hypertension	✓	✓	✓

[3-4] Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Nov 23, 2020.

[3-5] U. S. Government Publishing Office. (2017). *Electronic Code of Federal Regulations*. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-E/section-438.364. Accessed on: Nov 8, 2021.

DVHA's *Managing Hypertension* PIP submission documentation provided evidence that the PIP was a scientifically sound project supported by use of key research principles. **DVHA**'s PIP demonstrated strengths by achieving 100 percent of CMS' Protocol 1 requirements in the validation criteria in Steps 1 through 6. The PIP had not progressed to reporting data, testing, or implementing interventions (Steps 7–8); therefore, no conclusions could be drawn related to the PIP. Baseline data and quality improvement processes and strategies will be reported in the next annual EQR technical report.

DVHA demonstrated proficiency in designing a new PIP that has the potential to impact member health and functional status. **DVHA**'s performance indicator was based on HEDIS technical specifications and focused on measuring the rate of Vermont Medicaid members 18 to 85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled (<140/90 mm Hg). **DVHA** specified that a systematic hybrid data collection method following HEDIS technical specifications will be used for collecting baseline and remeasurement data.

Conclusions Related to Performance Measures

To draw conclusions about the **quality** and **timeliness** of, and **access** to care **DVHA** provided, HSAG determined which components of each performance measure could be used to assess these domains. Table 3-2 illustrates the **quality**, **timeliness**, and **access** domains related to the performance measures included in this report. Items marked not applicable (NA) are measures evaluating utilization of services.

Table 3-2—Performance Measures Activity Components Assessing Quality, Timeliness, and Access

Performance Measures	Quality	Timeliness	Access
Adults' Access to Preventive/Ambulatory Health Services			✓
Child and Adolescent Well-Care Visits	✓		✓
Breast Cancer Screening	✓		
Chlamydia Screening in Women	✓		
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment	✓	✓	✓
Ambulatory Care	NA	NA	NA
Well Child Visits in the First 30 Months of Life	✓		✓
Asthma Medication Ratio	✓		
Follow-Up After ED Visit for Mental Illness	✓	✓	✓
Follow-Up After ED Visit for AOD Abuse or Dependence	✓	✓	✓
Developmental Screening in the First 3 Years of Life	✓	✓	✓
Prenatal and Postpartum Care	✓	✓	✓
Controlling High Blood Pressure	✓		
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	✓		

DVHA continued to use an external software vendor with HEDIS Certified Measures to produce the HEDIS measures under review. Using a HEDIS Certified Measures vendor ensured that **DVHA**'s rates were calculated in accordance with HEDIS specifications and that the measures met standards set forth by NCQA. [**Quality**]

DVHA staff used trending mechanisms to monitor claims submissions which ensured data completeness prior to rate production. **DVHA** also refreshed administrative data frequently to ensure inclusion of the most recent claim information available for measure calculation. [**Quality**]

DVHA partnered with Gainwell Technologies (formerly DXC Technologies) to manage its core systems. **DVHA**'s oversight of Gainwell ensured that Gainwell met the requirements for data capture and HEDIS reporting. Gainwell actively participated in quality meetings and participated in **DVHA**'s virtual review. **[Quality]**

DVHA staff continued to review performance measures to identify areas for improvement and to identify mechanisms for improving outcomes for its beneficiaries. Several performance measures representing the **quality** and **timeliness** of, and **access** to care demonstrated strengths by meeting or exceeding the 90th percentile, including *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*.

DVHA should continue to monitor and trend claims submissions throughout the year. **[Quality**, **Access**, and **Timeliness]**

DVHA should continue to pursue all available data sources to supplement its data captured via claims. **DVHA** may benefit from the use of data from Vermont's clinical repository operated by VITL. The VITL repository, which retains patient information in a standardized format, could be used as an additional data source for future measure production. This will enhance measure rates by identifying additional values for numerator compliance. Using the VITL repository will impact the **quality** and **timeliness** of, and **access** to care received by beneficiaries.

Conclusions Related to Compliance With Standards

To draw conclusions about **quality** and **timeliness** of, and **access** to the care **DVHA** provided, HSAG determined which components of each compliance review standard could be used to assess these domains. Table 3-3 illustrates the **quality**, **timeliness**, and **access** domains related to the compliance review standards.

HSAG evaluated the standards reviewed during 2021–2022 and determined the following conclusions concerning the domains of **quality**, **timeliness**, and **access**. Table 3-3 illustrates the **quality**, **timeliness**, and **access** domains related to the compliance review standards.

Table 3-3—Compliance Review Standards Components Assessing Quality, Timeliness, and Access

Compliance Review Standards	Quality	Timeliness	Access
Standard I—Practice Guidelines	✓	✓	✓
Standard II—Quality Assessment and Performance Improvement (QAPI) Program	✓	✓	✓
Standard III—Health Information Systems	✓	✓	✓

Each of the compliance review standards included elements representing the domains of **quality**, **timeliness**, and **access**. *Met* elements in the standards reviewed this year addressed all three domains. HSAG offered the following conclusions and recommendations for continued performance improvement.

DVHA produced examples of clinical practice guidelines (CPGs) that were adopted and approved at the time of the virtual review, including Substance Use Disorder (SUD) Medication-assisted Treatment (MAT), Diabetes, and Applied Behavioral Analysis (ABA). The **DVHA** website included additional CPGs such as Developmental Screening for Young Children and Transcranial Magnetic Stimulation. **DVHA** should consider expanding its use of CPGs. Implementing additional CPGs could assist to improve the **quality** and **timeliness** of, and **access** to care for beneficiaries.

The **DVHA** Health Care Program Member Handbook informed beneficiaries of the use of CPGs for certain chronic illnesses and encouraged providers to use them to improve health outcomes. **DVHA** also informed beneficiaries that they could suggest ways to improve current programs and have their comments included as part of the quality assurance review by calling the Customer Support Center. Continuing to include providers' and beneficiaries' input into the quality assurance review process could assist **DVHA** in identifying areas of need and facilitate efforts to improve the **quality** and **timeliness** of, and **access** to care for beneficiaries.

The **DVHA** Quality Management (QM) Plan addressed ongoing QAPI activities that included detecting both under- and overutilization of services. **DVHA** had mechanisms in place to detect both of these activities. The Clinical Utilization Review Board (CURB) identified opportunities to improve quality, efficiencies, and adherence to relevant, evidence-based CPGs in the medical programs and recommended these opportunities to the Medicaid commissioner. The CURB examined high-cost, high-use services identified through the programs' medical claims data and reviewed existing utilization controls to identify areas in need of improved utilization review. **DVHA** implemented informal quality improvement projects on two topic areas (*chlamydia screening* and *adults' access to preventive/ambulatory health services*) after annual review of program performance by the DVHA Quality Committee, Managed Care Medical Committee, and the CURB. Continuing these activities could improve the **quality** and **timeliness** of, and **access** to care for beneficiaries.

DVHA addressed the **quality** of and **access** to care by adding new performance measures that focused on home and community-based services (HCBS) to the ongoing QAPI Program. The performance measures addressed both Developmental Disabilities Services (DDS) HCBS and Choices for Care (CFC). The new performance measures addressed the:

1. Proportion of people served in DDS HCBS who make choices about their everyday lives.
2. Proportion of people served in DDS HCBS who make decisions about their everyday lives.
3. Percentage of people in CFC who reported that they get to do the things they want to do outside the home as often as they want.
4. Percentage of people in CFC who reported that they can choose or change any of the services they receive.

The contract between **DVHA** and Gainwell specified the services and applications needed to support member management. The services and applications required for provider services included determining provider eligibility, credentialing providers, enrolling and disenrolling providers, managing provider information, assisting in handling inquiries concerning provider information, managing provider communications, performing provider outreach, managing provider grievances and appeals, and terminating providers. [**Quality** and **Timeliness**]

DVHA ensured that Medicaid beneficiaries received the services billed by preparing and mailing an Explanation of Medical Benefits (EOMB) quarterly to Medicaid beneficiaries. Each quarter, **DVHA** selected different specialists or different services to review. In Quarter 1 of 2021, the Program Integrity Unit sent 512 EOMBs to members concerning durable medical equipment (DME) and received 232 responses. The Program Integrity Unit prepared a summary of the project each quarter and included the findings from the survey on the EOMB Summary Sheet. [**Quality, Access, and Timeliness**]

DVHA Aggregated Conclusions Concerning Strengths and Weaknesses in the Domains of Access to Care, Timeliness of Care, and Quality of Care

Table 3-4—Aggregate Conclusions Regarding DVHA Strengths in Access, Quality, and Timeliness Domains

Quality	Access	Timeliness	Strengths
✓	✓		The compliance review revealed that the QM Plan addressed ongoing QAPI activities that included detecting both under- and overutilization of services. **DVHA** had a CURB that identified opportunities to improve quality, efficiencies, and adherence to relevant, evidence-based CPGs in the medical programs and recommended these opportunities to the Medicaid commissioner. The CURB examined high-cost, high-use services identified through the program's medical claims data and reviewed existing utilization controls to identify areas in need of improved utilization review. **DVHA** scored at or above the 95th percentile for the following utilization of services HEDIS measures, which affected **access** to care, **timeliness** of care, and **quality** of care: *Ambulatory Care (ED Visits)—1–9 Years.* Utilization measures scoring between the 90th and 95th percentile included *Ambulatory Care (ED Visits)—10–19 Years*, *Ambulatory Care (ED Visits)—20–44 Years*, and *Ambulatory Care (ED Visits)—45–64 Years.* The strength in these measures provides **DVHA** with the opportunity to impact the **quality** and **timeliness** of, and **access** to care.

Quality	Access	Timeliness	Strengths
✓	✓	✓	**DVHA** scored between the 75th and 90th percentile for the *Initiation and Engagement of AOD Abuse or Dependence Treatment (Engagement)—Total* measure. The compliance review activity identified a CPG available to **DVHA**'s providers that affected the **quality** and **timeliness** of, and **access** to care provided to beneficiaries. Use of the Vermont SUD MAT guidelines assisted **DVHA** in achieving a performance score meeting or exceeding the 75th percentile.

Table 3-5—Aggregated Conclusions Regarding DVHA Weaknesses in Access, Quality, and Timeliness of Care

Quality	Access	Timeliness	Weaknesses
✓			**DVHA** implemented a new PIP in state fiscal year (SFY) 2021–2022. The PIP focuses on the HEDIS measure *Controlling High Blood Pressure.* **Recommendation:** While HSAG could not compare this measure to benchmarks or to the prior year's rates due to a change in the specifications, **DVHA** needs to continue to focus on this PIP topic to successfully complete PIP validation for Activities 7, 8, and 9, which could increase the score for this HEDIS measure and improve the **quality** of care provided to members.
✓	✓	✓	**DVHA** scored below the 25th percentile for the following preventive care HEDIS measures: *Breast Cancer Screening* and *Chlamydia Screening in Women—Total.* Related to this, the compliance review activity identified CPGs available to **DVHA**'s providers that could positively impact rates for these measures: *Preventive Screenings/Care Recommendations: U.S. Preventive Services Task Force A and B Recommendations.* **Recommendation:** To verify providers have the necessary tools to provide preventive services and screenings and improve related HEDIS measures, **DVHA** should consider adopting additional CPGs related to preventive health services and distribute CPGs to all PCPs with a reminder of the importance of ensuring that members receive appropriate preventive health screenings during every office visit.
✓	✓	✓	**DVHA** scored below the 50th percentile for the following utilization of services HEDIS measures, which could affect **access** to care, **timeliness** of care, and **quality** of care: *Adults' Access to Preventive/Ambulatory Health Services—Total, Ambulatory Care—(ED Visits) 65–74 Years, Ambulatory Care—(ED Visits) 75–84 Years, and Ambulatory Care—(ED Visits) 85+ Years.* **Recommendation: DVHA** should consider having the CURB review the findings of the HEDIS utilization measures to detect under- or overutilization of services in adults ages 65 to 85+ and work collaboratively to improve the HEDIS utilization measure scores. This activity could positively impact the **quality** and **timeliness** of, and **access** to care provided to beneficiaries.

4. Assessment of Vermont's Quality Strategy

Background

As specified in 42 CFR §438.340(b)(2), a State's quality strategy must include goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of all populations served. The Vermont Medicaid Comprehensive Quality Strategy listed the following Global Commitment to Health Demonstration goals: *to increase access to care, contain health care cost, improve the quality of care, and eliminate institutional bias.* The Vermont Medicaid Managed Care Program Objectives identified priority areas, established performance targets, and offered time frames for achieving the objectives.

The Vermont Medicaid Comprehensive Quality Strategy addressed the requirements of 42 CFR §438.340(b)(3)(i) related to quality metrics and performance targets. Vermont requires **DVHA** to report performance measures. **DVHA** collects, analyzes, and reports on the following sets of measures: Global Commitment to Health Core Measure Set/HEDIS, CMS Adult Core Measure Set, CMS Child Core Measure Set, and Experience of Care and Health Outcomes[4-1] measures (i.e., Consumer Assessment of Healthcare Providers and Systems [CAHPS®][4-2] survey). The Vermont Medicaid Global Commitment to Health waiver program has selected performance targets and metrics, including preventive care and annual care measures.

The Vermont Quality Strategy defined measures and baseline rates using NCQA's Quality Compass[4-3] national Medicaid health maintenance organization (HMO) percentiles for HEDIS. Vermont established the 50th percentile annually as the benchmark for access to care and quality of care measures. Table 4-1 displays those measures and identifies the five-year goal listed in the quality strategy. The table compares the MY 2018 rate with the MY 2019 and MY 2020 performance scores for those measures. The table also identifies the percentile achieved for MY 2020.

Table 4-1—Quality Strategy Goals Comparison of MY 2018, 2019, and MY 2020 Performance Rates

Quality Strategy Goal (1/1/2017—12/31/2021)	Performance Measure	MY 2018 Performance Score	MY 2019 Performance Score	MY 2020 Performance Score	MY 2020 Percentile Rank
AHS will maintain its performance in preventive/ambulatory care visits of Adult Medicaid managed care beneficiaries over the next five years [**Quality** and **Access**]	*Adults' Access to Preventive/Ambulatory Health Services—Total*	81.70%	83.30%	78.46%	25th–50th

4-1 ECHO® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
4-2 CAHPS® is a registered trademark of the AHRQ.
4-3 Quality Compass® is a registered Trademark of the National Committee for Quality Assurance (NCQA).

Quality Strategy Goal (1/1/2017—12/31/2021)	Performance Measure	MY 2018 Performance Score	MY 2019 Performance Score	MY 2020 Performance Score	MY 2020 Percentile Rank
AHS will demonstrate an improvement in enrollee breast cancer screening over the next five years [**Quality, Timeliness,** and **Access**]	*Breast Cancer Screening*	54.30%	52.33%	48.57%	10th–25th
AHS will demonstrate an improvement in enrollee chlamydia screening in women ages 16–24 years over the next five years [**Quality, Timeliness,** and **Access**]	*Chlamydia Screening in Women—Total*	53.20%	52.98%	46.46%	10th–25th
AHS will demonstrate an improvement in follow-up after hospitalization for mental illness (7 day) over the next five years [**Quality, Timeliness,** and **Access**]	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-Up—Total*	52.70%	38.73%	45.05%	75th–90th
AHS will demonstrate an improvement in follow-up after hospitalization for mental illness (30 day) over the next five years [**Quality, Timeliness,** and **Access**]	*Follow-Up After Hospitalization for Mental Illness—30-day Follow-Up—Total*	71.80%	60.50%	64.75%	50th–75th
AHS will demonstrate an improvement in initiation and engagement of AOD dependence treatment over the next five years [**Quality, Timeliness,** and **Access**]	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total—Total*	46.60%	43.22%	45.04%	50th–75th
AHS will demonstrate an improvement in initiation and engagement of AOD dependence treatment over the next five years [**Quality, Timeliness,** and **Access**]	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total—Total*	23.90%	22.16%	22.61%	75th–90th
AHS will demonstrate an improvement in controlling enrollee high blood pressure over the next five years [**Quality, Timeliness, and Access**]	*Controlling High Blood Pressure*	49.40%	--	42.58%	NC*

*NC indicates that a comparison to benchmarks or to the prior year's rates is not appropriate either due to a change in specifications or because HEDIS MY 2020 is the first year this measure is being reported.

DVHA achieved or exceeded the benchmark of the 50th percentile rate for four of the seven measures listed in Table 4-1.

Recommendations

It is possible that COVID-19 impacted performance rates due to the public health emergency and temporary closing of providers' offices. Behavioral health performance measure improvements could have been impacted by increased access to telehealth services.

To improve preventive care and access-related performance measures, AHS should consider focusing improvement efforts on the recommendations listed below.

- The Vermont Quality Strategy maintained that AHS' monitoring activities included requiring **DVHA** and the Departments to provide evidence of having adopted CPGs for the treatment of at least two acute or chronic health conditions. To strengthen the Quality Strategy, AHS should consider requiring the adoption of additional CPGs for performance areas that have demonstrated a decreased performance rate or have not achieved the target performance rate, such as controlling high blood pressure, breast cancer screening, and chlamydia screening. Including CPGs for these performance areas could improve the **quality** and **timeliness** of, and **access** to care provided to beneficiaries.
- AHS should consider requiring **DVHA** to identify health care disparities within the preventive care and access-related performance measure data to focus its quality improvement and PIP efforts on disparate populations. Improvement efforts in these areas could impact the **quality** and **timeliness** of, and **access** to care provided to beneficiaries.
- Periodically, HEDIS measures may be retired, or performance measure specifications may be modified. AHS should consider reviewing the Quality Strategy priority areas and associated objectives and performance targets to ensure these objectives and performance targets align with current HEDIS performance measure specifications. Periodic review of priority areas, objectives, and performance targets could impact the **quality** and **timeliness** of, and **access** to care provided to beneficiaries.
- To strengthen the Quality Strategy, AHS could consider establishing specific objectives, quantifiable performance targets, and interventions associated with continuous quality improvement efforts to improve and sustain optimal performance rates. Once specific objectives and interventions have been established for performance measures, AHS could review performance indicator rates and identify opportunities for improvement in the **quality** and **timeliness** of, and **access** to care. After opportunities for improvement are identified, AHS may prioritize areas of low performance and define quantifiable improvement targets to indicators so that **DVHA** and other key stakeholders may know the level of achievement that is expected in future years.
- AHS also could consider establishing a methodology for reducing the gap between the performance measure rates and achieving the established goals. For example, AHS could recommend reducing the gap between the actual rate and the performance measure goal by 10 percent annually. Identifying the desired improvement percentages and specifying improvement targets based on the current rates for each measure could impact the **quality** and **timeliness** of, and **access** to care for beneficiaries.

- **DVHA** could consider conducting telephone outreach or virtual member focus groups to determine barriers to care that exist for beneficiaries eligible to receive mammograms or chlamydia screenings with Pap smears (i.e., lack of telephone to schedule appointments, lack of transportation, lack of childcare, homelessness). This could improve the **timeliness** of and **access** to care**.**
- **DVHA** also could consider implementing measures to ensure appointment availability to primary care providers and obstetricians/gynecologists for access to breast cancer and chlamydia screenings. This could improve the **timeliness** of and **access** to care.
- AHS/**DVHA** also could consider incentive payments to beneficiaries for preventive care visits, which could improve the **timeliness** of and **access** to care, and impact preventive care performance rates.
- AHS could work with hospitals to ensure that they notify **DVHA** when members are hospitalized for mental illness. The notification could trigger immediate contact with the member and the member's provider to assist in scheduling the follow-up visit within seven days. **DVHA** could also ensure that member information contains the correct telephone contact number to assist in communicating with the member after discharge. These efforts could improve the **quality** and **timeliness** of, and **access** to care.
- **DVHA** could consider giving beneficiaries blood pressure monitors to ensure they have a mechanism to monitor blood pressure at home. This effort could improve the **quality** and **timeliness** of, and **access** to care and impact the *Controlling High Blood Pressure* performance measure.
- **DVHA** could consider focusing improvement efforts on ensuring that providers and community mental health centers have the capacity to initiate drug dependence treatment for newly diagnosed members. Implementing improvement efforts in this area could impact the **quality** and **timeliness** of, and **access** to care provided to beneficiaries.

5. Description of External Quality Review Activities

Validation of Performance Improvement Project

During the 2021–2022 EQR contract year with AHS, HSAG validated one PIP conducted by **DVHA**. This section describes the processes HSAG used to complete the validation activities. HSAG described the details related to its approach, methodologies, and findings from the *Managing Hypertension* PIP validation activities in its Performance Improvement Projects Validation Report for **DVHA**. HSAG provided this report to AHS and **DVHA**.

Objectives and Background Information

The AHS quality strategy required **DVHA** to conduct a PIP in accordance with 42 CFR §438.330(b)(1). The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. This structured method of assessing and improving the Medicaid managed care model organizations' processes is expected to have a favorable effect on health outcomes and beneficiary satisfaction. AHS contracted with HSAG as the EQRO to meet the federal Medicaid managed care requirement for validating **DVHA**'s PIP. Validation of PIPs is a CMS mandatory activity.

The primary objective of HSAG's PIP validation was to determine **DVHA**'s compliance with requirements set forth in 42 CFR §438.330(d)(2)(i-iv), including:

- Measurement of performance using objective quality indicators.
- Implementation system interventions to achieve improvement in the access to and quality of care.
- Evaluating the effectiveness of the interventions.
- Planning and initiation of activities for increasing and sustaining improvement.

Description of Data Obtained

HSAG reviewed the documentation **DVHA** submitted for the one PIP validated by HSAG. The PIP was submitted using HSAG's PIP Submission Form, which HSAG developed to collect all required data elements for the PIP validation process. **DVHA** completed the PIP Submission Form following instructions provided by the HSAG PIP Team regarding the level of documentation required to address each PIP evaluation element. **DVHA** also was instructed to submit any supporting documentation that could provide further details and background information. HSAG was available to provide technical assistance throughout the PIP process. **DVHA** achieved all validation criteria with the first submission, and a resubmission was not necessary.

Technical Methods of Data Collection/Analysis

Data Collection Methods

Table 5-1—Performance Improvement Project Topics, HEDIS Measure, and Data Source for DVHA

PIP Topic	HEDIS Measure	Data Source
Managing Hypertension	*CBP*	*Hybrid*

HSAG conducted the validation consistent with the CMS publication, *Protocol 1: Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, cited earlier in this report. HSAG, with AHS' input and approval, developed the PIP Validation Tool to ensure uniform and consistent validation of the PIP. Using this tool, HSAG determined the overall methodological validity of the PIP, and in future submissions, will determine the overall success in achieving significant and sustained improvement. Over the course of the PIP, HSAG will validate the following CMS Protocol 1 steps:

- Step 1—Review the Selected PIP Topic
- Step 2—Review the PIP Aim Statement
- Step 3—Review the Identified PIP Population
- Step 4—Review the Sampling Method
- Step 5—Review the Selected PIP Indicator(s)
- Step 6—Review the Data Collection Procedures
- Step 7—Review Data Analysis and Interpretation of Results
- Step 8—Assess the Improvement Strategies
- Step 9—Assess for Significant and Sustained Improvement

HSAG's PIP validation process consisted of two independent validations that included a validation by team members with expertise in statistics, PIP design and methodology, and quality and performance improvement. The PIP team conducted the validation process as follows:

- HSAG reviewed the PIP submission documentation to ensure that all required documentation was received.
- HSAG conducted the validation, and the PIP Validation Tool was completed.
- HSAG reconciled the scores by a secondary review. If the two reviewers produced scoring discrepancies, the PIP Team discussed the discrepancies and reached a consensus for the final evaluation element score(s).
- Each required CMS Protocol 1 step consisted of evaluation elements necessary to complete the validation of that activity. The PIP Team scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable* (*NA*), or *Not Assessed*. To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All critical elements must have received

a *Met* score to produce valid and reliable results. The scoring methodology included the *NA* designation for situations in which the evaluation element did not apply to the PIP. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining activities. HSAG used a General Comment when documentation for an evaluation element included the basic components to meet the requirements for the element (as described in the narrative of the PIP); however, enhanced documentation would demonstrate a stronger application of the CMS Protocol 1.

- HSAG's criteria for determining the score were as follows:
  - *Met*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met,* and 80 percent to 100 percent of all evaluation elements were *Met* across all activities.
  - *Partially Met:* Low confidence in reported PIP results. All critical elements were *Met* and 60 percent to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met.*
  - *Not Met:* All critical evaluation elements were *Met* and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met.*
  - *Not Applicable (NA):* Elements designated *NA* (including critical elements) were removed from all scoring.
  - *Not Assessed*: Elements (including critical elements) were removed from all scoring.
- In addition to a validation status (e.g., *Met*), HSAG gave the PIP an overall percentage score for all evaluation elements (including critical elements), which was calculated by dividing the total elements *Met* by the sum of all applicable elements that were assessed (as *Met*, *Partially Met*, and *Not Met*). A critical element percentage score was then calculated by dividing the total critical elements *Met* by the sum of the applicable critical elements that were assessed (as *Met*, *Partially Met*, and *Not Met*).
- After completing the validation, HSAG prepared the draft and final **DVHA** Performance Improvement Projects Validation Report for AHS and **DVHA**.

Determining Conclusions

To draw conclusions about the **quality** and **timeliness** of, and **access** to care **DVHA** provided, HSAG determined which components of the PIP could be used to assess these domains. During 2021, the **DVHA** PIP completed Activities 1–6 and had not progressed to reporting data, testing, or implementing interventions. Therefore, no conclusions could be drawn related to the PIP. These conclusions will be formulated after completing the Implementation phase of the PIP, Steps 7 and 8, upon reporting data, testing, and implementing interventions. Baseline data and quality improvement processes and strategies will be reported in the next annual EQR technical report.

Validation of Performance Measures

Validation of performance measures is a CMS mandatory EQR activity required by the BBA. State Medicaid agencies must ensure that performance measures reported by their MCOs are validated. The state, its agent that is not an MCO, or an EQRO, can perform this validation. HSAG, the EQRO for AHS, conducted the validation activities. For MY 2020, **DVHA** provided physical, mental, and behavioral health services to Medicaid-eligible recipients. HSAG validated a set of performance measures selected by AHS that were calculated and reported by **DVHA**. HSAG conducted the validation activities as outlined in the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019, cited earlier in this report.

Objectives and Background Information

The primary objectives of HSAG's validation process were to:

- Evaluate the accuracy of the performance measure data **DVHA** collected.
- Determine the extent to which the specific performance measures calculated by **DVHA** followed the specifications established for each performance measure.

AHS selected 15 HEDIS measures for HSAG's validation. The measurement period addressed in this report was MY 2020.

Description of Data Obtained

As identified in the CMS protocol, the types of data the EQRO should use to complete the performance measure validation task include:

- The **Record of Administration, Data Management, and Processes (Roadmap)**, which was completed by **DVHA**. The Roadmap provides background information concerning **DVHA**'s policies, processes, system capabilities, and data in preparation for the virtual review validation activities.
- **Supporting documentation**, including file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations logic or extracts.
- **Current and prior years' performance measure results**, which were obtained from **DVHA**.
- **Virtual review interviews and demonstrations**, which were conducted by HSAG. Information was obtained through interaction, discussion, and formal interviews with key **DVHA** staff members, as well as observation of data processing functions and demonstrations.

Note: Typically, the EQRO also reviews the source code used to calculate the performance measures. **DVHA** continued to contract with a software vendor to calculate the HEDIS measures. Since all the performance measures under the scope of this validation were approved by NCQA in the measure certification program, HSAG did not perform additional source code review.

Technical Methods of Data Collection/Analysis

HSAG followed the same process when validating each performance measure, which included the following steps:

Pre-Virtual Review Activities:

- **DVHA** was required to submit a completed Roadmap to HSAG. HSAG performed a cursory review of the Roadmap to ensure that each section was complete and that all applicable attachments were present. The review team used the Roadmap to determine if the systems' capabilities were sufficient to report the HEDIS measures.
- **DVHA** completed the medical record review (MRR) section within the Roadmap. In addition, HSAG requested and reviewed the following attachments: medical record hybrid tools and instructions, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. To ensure the accuracy of the hybrid data being abstracted by **DVHA**, HSAG requested that **DVHA** participate in the review of a convenience sample.
- **DVHA** used a software vendor with HEDIS Certified Measures for HEDIS MY 2020 calculation and reporting. All performance measures under the scope of this review were certified by NCQA for HEDIS MY 2020; therefore, **DVHA** was not required to submit source code.
- HSAG reviewed previous years' validation of performance measures reports to assess for trending patterns and rate reasonability.

Virtual Review Activities:

- HSAG conducted an opening session to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
- HSAG's evaluation of systems included a review of the information systems, focusing on the processing of claims and encounter data, patient data, and provider data. Based on the desk review of the Roadmap, HSAG conducted interviews with key **DVHA** staff members familiar with the processing, monitoring, and calculation of the performance measures to confirm findings from the documentation review; expand or clarify outstanding issues; and verify that written policies and procedures were used and followed in daily practice.
- HSAG completed an overview of data integration and control procedures. HSAG also reviewed any supporting documentation for data integration and addressed data control and security procedures. HSAG evaluated the data collection and calculation processes, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). HSAG conducted primary source verification to validate the output files. This was accomplished by tracking the cases back through the information systems to the original data source and confirming numerator, denominator, and enrollment/eligibility criteria.

- HSAG conducted a closing conference to summarize preliminary findings based on the review of the Roadmap and virtual review activities (including any measure-specific concerns) and discussed follow-up actions.

Post-Virtual Review Activities:

- HSAG evaluated follow-up documentation **DVHA** provided to address measure-specific issues.
- HSAG evaluated **DVHA**'s performance measure results and compared them to the prior years' performance and national Medicaid benchmarks.

Determining Conclusions

To draw conclusions about the **quality** and **timeliness** of, and **access** to care that **DVHA** provided, HSAG determined which components of each performance measure could be used to assess these domains. Upon HSAG's evaluation of the performance measure results, HSAG assigned a validation finding to each performance measure.

Monitoring of Compliance With Standards

Monitoring compliance with federal Medicaid managed care regulations and the applicable State contract requirements is one of the CMS mandatory activities. AHS contracted with HSAG to perform the **DVHA** compliance review. HSAG followed the guidelines in CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019, cited earlier in this report.

Objectives and Background Information

According to 42 CFR §438.358,[5-1] a review to determine an MCO's, PIHP's, PAHP's, or PCCM's compliance with state standards must be conducted within a three-year period by a state Medicaid agency, its agent, or an EQRO. These standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438—Managed Care. To meet these requirements, AHS:

- Continued to ensure that its IGA with **DVHA** included the applicable CMS Medicaid managed care requirements and that they were at least as stringent as the CMS requirements.
- Contracted with HSAG as its EQRO to conduct reviews to assess **DVHA**'s performance in complying with the federal Medicaid managed care regulations and AHS' associated IGA with **DVHA**.

[5-1] U. S. Government Publishing Office. (2018). *Electronic Code of Federal Regulations.* Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0fe554e3f4a6236efe0d8c0aa9319e57&mc=true&n=pt42.4.438&r=PART&ty=HTML#se42.4.438_1358. Accessed on: Nov 5, 2021.

- Maintained its focus on encouraging and supporting **DVHA** in targeting areas for continually improving its performance in providing quality, timely, and accessible care to beneficiaries.
- Requested that, as allowed by CMS, HSAG continue its three-year cycle of reviewing **DVHA** performance in complying with the federal Medicaid managed care regulations. This gives **DVHA** time to focus its improvement efforts and implement new initiatives. For the review covered by this report, AHS requested that HSAG review the CMS requirements described at 42 CFR §438.236, §438.242, and §438.330, and the associated AHS IGA requirements. The primary objective of HSAG's review was to provide meaningful information to AHS and **DVHA** to use to:
  - Evaluate the quality and timeliness of, and access to, care and services **DVHA** and its IGA partners furnished to beneficiaries.
  - Identify, implement, and monitor interventions to continue to drive performance improvement for these aspects of care and services.

HSAG assembled a review team to:

- Collaborate with AHS to determine the scope of the review as well as the scoring methodology, data collection methods, desk review and virtual review activities and timelines, and virtual review agenda.
- Collect data and documents from AHS and **DVHA** and review them before and during the virtual review.
- Conduct the virtual review.
- Aggregate and analyze the data and information collected.
- Prepare the report of its findings and any recommendations or suggestions for improvement.

HSAG compiled and submitted to AHS, for its review and approval, a data collection tool to assess and document **DVHA**'s compliance with the Medicaid managed care regulations, State rules, and the associated AHS/**DVHA** IGA requirements. The review tool included requirements that addressed three performance areas associated with the CMS Medicaid managed care regulations described at §438.236, §438.242, and §438.330.

I. Practice Guidelines

II. Quality Assessment and Performance Improvement (QAPI) Program

III. Health Information Systems

As these same standards were reviewed during four prior audits (i.e., 2009, 2012, 2015, and 2018), HSAG evaluated **DVHA**'s current performance and compared the results to those from the earlier reviews of these same standards.

Description of Data Obtained

Table 5-2—Description of DVHA's Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation **DVHA** submitted for HSAG's desk review and additional documentation available to HSAG during the virtual review	August 1, 2020–June 16, 2021
Information obtained through interviews with **DVHA** staff members	June 16, 2021

To assess **DVHA**'s compliance with federal regulations, State rules, and contract requirements, HSAG obtains information from a wide range of written documents produced by **DVHA**, including, but not limited to, the following for the SFY 2021 compliance review:

- Committee meeting agendas, minutes, and handouts
- Written policies, procedures, and other plan documents with creation or revision dates prior to the end of the review period (i.e., June 16, 2021)
- The Member Handbook, newsletters, and additional documents sent to members
- The Provider Manual, newsletters, and other **DVHA** communication to providers/subcontractors
- The automated member website
- The automated provider portal and directory
- Narrative and/or data reports across a broad range of performance and content areas
- MCO Questionnaire sent to the MCO with the pre-site documents

HSAG obtains additional information for the compliance review through interactive discussions and interviews with **DVHA**'s key staff members.

Technical Methods of Data Collection/Analysis

Using the AHS-approved data collection tool, HSAG performed a desk review of **DVHA**'s documents and a virtual review that included reviewing additional documents and conducting interviews with key **DVHA** staff members. Pre-virtual review activities included:

- Developing the compliance review tool HSAG used to document its findings from the review of policies, procedures, reports, and additional plan documents. The compliance tool also included sections to insert findings from the virtual interviews conducted with **DVHA** staff members.
- Preparing and forwarding to **DVHA** a customized desk review request form and instructions for submitting the requested documentation to HSAG for its desk review. The form provided information about HSAG's compliance review activities and the timelines/due dates for each.
- Developing and providing to **DVHA** the detailed agenda for the two-day virtual review.

- Responding to any questions **DVHA** had about HSAG's desk- and virtual review activities and the documentation required from **DVHA** for HSAG's desk review.
- Conducting a pre-virtual desk review of **DVHA**'s key documents and other information obtained from AHS. The desk review enabled HSAG reviewers to increase their knowledge and understanding of **DVHA**'s operations, identify areas needing clarification, and begin compiling and documenting preliminary findings and interview questions before the virtual review.

For the review activities, two HSAG reviewers conducted the two-day virtual review, which included:

- An opening conference, with introductions; **DVHA** staff members' overview of **DVHA** and its relationship with its IGA partners, providers, and subcontractors; **DVHA** updates concerning any changes and challenges occurring since HSAG's previous review; a review of the agenda and logistics for HSAG's virtual activities; HSAG's overview of the process it would follow in conducting the virtual review; and the tentative timelines for providing **DVHA** and AHS a draft report for AHS' and **DVHA**'s review and comment.
- Review of the documents HSAG requested that **DVHA** had available during the virtual review.
- Interviews with **DVHA**'s key administrative and program staff members. Separate interviews were scheduled and conducted for each of the standards included in the review tool.
- A closing conference during which HSAG reviewers summarized their preliminary findings. For each standard, the findings included HSAG's assessment of **DVHA**'s performance strengths; any anticipated required corrective actions and reviewers' suggestions that could further enhance **DVHA**'s processes; documentation; performance results; and the quality, access to, and timeliness of services provided to beneficiaries.

HSAG reviewers documented their findings in the compliance review tool. The tool served as a comprehensive record of the desk review and virtual review activities and the performance scores achieved by **DVHA**. HSAG made recommendations for any element that was scored as *Partially Met* or *Not Met,* and offered suggestions to **DVHA** to further strengthen and drive continued improvement in **DVHA**'s performance. HSAG included the completed tool as one section of the compliance report. Table 5-3 lists the major data sources HSAG used in determining **DVHA**'s performance in complying with requirements and the time period to which the data applied. Table 5-3 also presents a more detailed, chronological description of the above activities that HSAG performed during its review.

Table 5-3—The Compliance Review Activities HSAG Performed

Step 1:	Established the review schedule.
	Before the review, HSAG coordinated with AHS and **DVHA** to develop the compliance review timeline and assigned HSAG reviewers to the review team.

Step 2:	**Prepared the data collection tool for the standards included in this year's review and submitted it to AHS for review and comment.**
	To ensure that all applicable information was collected, HSAG developed a compliance review tool consistent with CMS protocols. HSAG used the requirements in the IGA between AHS and **DVHA** to develop the standards (groups of requirements related to broad content areas) to be reviewed. HSAG also used Version 2.0 of the federal Medicaid managed care protocols effective October 2019. Additional criteria used in developing the monitoring tool included applicable State and federal requirements. Prior to finalizing the tool, HSAG submitted the draft report to AHS for its review and comments.
Step 3:	**Prepared and submitted the Desk Review Form to DVHA.**
	HSAG prepared and forwarded a desk review form to **DVHA** and requested that **DVHA** submit specific information and documents to HSAG within a specified number of days of the request. The desk review form included instructions for organizing and preparing the documents related to the review of the standards, submitting documentation for HSAG's desk review, and having additional documents available for HSAG's virtual review.
Step 4:	**Forwarded a Documentation Request and Evaluation Form to DVHA.**
	HSAG forwarded to **DVHA**, as an accompaniment to the desk review form, a documentation request and evaluation form containing the same standards and AHS IGA (i.e., contract) requirements as the tool HSAG used to assess **DVHA**'s compliance with each of the requirements within the standards. The desk review form included detailed instructions for completing the "Evidence/Documentation as Submitted by **DVHA**" portion of this form. This step (1) provided the opportunity for **DVHA** to identify for each requirement the specific documents or other information that provided evidence of its compliance with the requirement, and (2) streamlined the HSAG reviewers' ability to identify all applicable documentation for their review.
Step 5:	**Developed a virtual review agenda and submitted the agenda to DVHA.**
	HSAG developed the agenda to assist **DVHA** staff members in their planning to participate in HSAG's virtual review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective virtual review and minimizing disruption to the organization's day-to-day operations. An agenda sets the tone and expectations for the virtual review so that all participants understand the process and time frames allotted for the reviews.
Step 6:	**Provided technical assistance.**
	As requested by **DVHA**, and in collaboration with AHS, HSAG staff members responded to any **DVHA** questions concerning the requirements HSAG used to evaluate its performance.

Step 7:	Received DVHA's documents for HSAG's desk review and evaluated the information before conducting the virtual review.
	HSAG compiled and organized the information and documentation, and reviewers used the documentation **DVHA** submitted for HSAG's desk review to gain insight into areas such as **DVHA**'s development of CPGs, dissemination of the guidelines to providers and beneficiaries, QAPI initiatives and activities, and **DVHA**'s operations, resources, and information systems. Reviewers then: • Documented in the review tool their preliminary findings after reviewing the materials **DVHA** submitted as evidence of its compliance with the requirements. • Identified any information not found in the desk review documentation in order to request it prior to the virtual review. • Identified areas and questions requiring further clarification or follow-up during the virtual interviews.
Step 8:	**Conducted the virtual portion of the review.**
	During the virtual review, staff members from **DVHA** answered questions and assisted the HSAG review team in locating specific documents or other sources of information. HSAG's activities completed during the virtual review included the following: • Convening an opening conference that included introductions, HSAG's overview of the virtual review process and schedule, **DVHA**'s overview of its structure and processes, and a discussion about any changes needed to the agenda and general logistical issues. • Conducting interviews with **DVHA**'s staff. HSAG used the interviews to obtain a complete picture of **DVHA**'s compliance with the federal Medicaid managed care regulations and associated AHS IGA requirements, explore any issues not fully addressed in the documents that HSAG reviewed, and increase HSAG reviewers' overall understanding of **DVHA**'s performance. • Reviewing additional documentation. HSAG reviewed additional documentation during the virtual review and used the review tool to identify relevant information sources and document its review findings. Items reviewed included, but were not limited to, written policies and procedures, minutes of key committee or other group meetings, and data and reports across a broad range of areas. During the virtual review, **DVHA** staff members also discussed the organization's information system data collection process and reporting capabilities related to the standards HSAG reviewed. • Summarizing findings at the completion of the virtual portion of the review. As a final step, HSAG conducted a closing conference to provide **DVHA**'s staff members and AHS participants with a high-level summary of HSAG's preliminary findings. For each of the standards, the findings included HSAG's assessment of **DVHA**'s strengths; if applicable, any areas requiring corrective actions; and HSAG's suggestions for further strengthening **DVHA**'s processes, performance results, and/or documentation. • **DVHA** staff members were readily available throughout the virtual review to answer HSAG's review questions and to assist in locating specific documents or other sources of information.

Step 9:	Documented reviewer findings in the Documentation Request and Evaluation Tool.
	Beginning prior to and continuing through the virtual review, HSAG reviewers documented their preliminary findings related to **DVHA**'s performance for each requirement. Following the virtual review, the reviewers completed the tool and finalized documenting **DVHA**'s strengths; required corrective actions; and any suggestions for further strengthening **DVHA**'s performance related to the written documentation and to providing accessible, timely, and quality services to enrollees.
Step 10:	**Calculated the individual scores and determined the overall compliance score for performance.**
	HSAG evaluated and analyzed **DVHA**'s performance in complying with the requirements in each of the standards contained in the review tool. HSAG used *Met*, *Partially Met*, and *Not Met* scores to document the degree to which **DVHA** complied with each of the requirements. A designation of *NA* was used if an individual requirement did not apply to **DVHA** during the period covered by the review. For each of the standards, HSAG calculated a percentage of compliance score and then an overall percentage of compliance score across all the standards.
Step 11:	**Prepared a report of findings and if required, corrective actions.**
	After completing the documentation of findings and scoring for each of the standards, HSAG prepared a draft report that described HSAG's compliance review findings; the scores assigned for each requirement within the standards; HSAG's assessment of **DVHA**'s strengths; any areas requiring corrective action; and HSAG's suggestions for further enhancing **DVHA**'s performance results, processes, and documentation. HSAG forwarded the report to AHS and **DVHA** for their review and comment. Following AHS' approval of the draft, HSAG issued the final report to AHS and **DVHA**.

Determining Conclusions

While the focus of a compliance review is to evaluate if **DVHA** correctly implemented the federal and State requirements, the results of the review can also determine areas of strength and weakness for **DVHA** related to ***access to care***, ***timeliness of care***, or ***quality of care***. Once HSAG calculates the scores for each standard, the reviewers evaluate each element scoring *Met*, *Partially Met*, and *Not Met* to determine how the elements relate to the three domains as defined on page 3-1. At that point, HSAG can draw conclusions for **DVHA** concerning ***access to care***, ***timeliness of care***, or ***quality of care*** from the results of the compliance review.

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which **DVHA**'s performance complied with the requirements. HSAG used a designation of *NA* when a requirement was not applicable to **DVHA** during the period covered by HSAG's review. This scoring methodology is defined as follows:

Met indicates full compliance, defined as *both* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as *either* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as *either* of the following:

- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For a provision with multiple components, key components of the provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall finding of noncompliance for the provision, regardless of the findings noted for the remaining components.

From the scores it assigned to **DVHA**'s performance for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by adding the weighted value of the scores for each requirement in the standard—i.e., *Met* (value: 1 point), *Partially Met* (value: 0.50 points), *Not Met* (value: 0.00 points), and *Not Applicable* (value: 0.00 points)—and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across all the standards by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the results by the total number of applicable requirements). If requested, HSAG also can assist in the review of corrective action plans (CAPs) from **DVHA** to determine if their proposed corrections will meet the intent of the requirements that were scored *Partially Met* or *Not Met*.

Standards Required by CMS to Be Included in EQR Compliance Reviews

CMS established the required activities that must be monitored by EQROs during the review, conducted within the previous three-year period, to determine the MCO's compliance with the standards, and validation of network adequacy (pending the publications of the protocols for that activity). The topics required to be included in the compliance reviews are defined in 42 CFR §438 Subpart D, §438.56, §438.100, §438.114, and §438.330 of the BBA, and the State contractual requirements.[5-2,5-3,5-4] Those

[5-2] U.S. Government Printing Office. (2019). *Title 42 Part 438 Subpart D*. Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_subpartD_section438.206. Accessed on Oct 5, 2021.

[5-3] U.S. Government Printing Office. (2019). *U.S. Code of Federal Regulations Title 42 Subpart E*. Available at: https://www.govregs.com/regulations/expand/title42_chapterIV_part438_subpartE_section438.330. Accessed on: Oct 5, 2021.

[5-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care*, §15, page 72818, Nov 2020. Available at:

requirements are shown in Table 5-4. The 2021–2022 compliance review included standards for Year 2 of the three-year cycle.

AHS elected to establish a cycle of reviewing one-third of the compliance review standards each fiscal year. HSAG and AHS established the three-year cycle in 2007–2008, the first year that HSAG operated as the EQRO for Vermont. That same cycle has been maintained for the compliance reviews throughout the years. The cycle was established to ensure that the HSAG reviewed the required CFR elements at least every three years. Table 2-8 lists the overall scores achieved during the compliance reviews each year. Table 5-4 includes the location of the requirements in the Vermont compliance tool and the year those requirements are included in the compliance review.

Table 5-4—CMS Requirements, Location of Requirements in the Vermont Compliance Tool, and Year Requirements Are Reviewed

CFR	CMS Standard	Standard in Vermont Compliance Tool	Year the Requirements Are Reviewed in Vermont		
			Year 3 2019–2020	Year 1 2020–2021	Year 2 2021–2022
§438.56	Disenrollment: Requirements and Limitations	Standard VII—Disenrollment Requirements	X		
§438.100	Enrollee Rights	Standard IV—Beneficiary Rights		X	
§438.114	Emergency and Poststabilization Services	Standard VI—Emergency and Poststabilization Services	X		
§438.206	Availability of Services	Standard I—Availability of Services	X		
		Standard II—Furnishing of Services	X		
		Standard III–Beneficiary Information		X	
		Standard VI—Emergency and Poststabilization Services	X		
§438.207	Assurances of Adequate Capacity and Services	Standard II—Furnishing of Services	X		
§438.208	Coordination and Continuity of Care	Standard I—Availability of Services	X		
		Standard IV—Coordination and Continuity of Care	X		

https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Nov 22, 2021.

CFR	CMS Standard	Standard in Vermont Compliance Tool	Year the Requirements Are Reviewed in Vermont		
			Year 3 2019–2020	Year 1 2020–2021	Year 2 2021–2022
§438.210	Coverage and Authorization of Services	Standard V—Coverage and Authorization of Services	X		
§438.214	Provider Selection	Standard I—Provider Selection		X	
		Standard II—Credentialing and Recredentialing		X	
§438.224	Confidentiality	Standard V—Confidentiality		X	
§438.228	Grievance and Appeals System	Standard VI—Grievance System—Beneficiary Grievances		X	
		Standard VII—Grievance System—Beneficiary Appeals and State Fair Hearings		X	
§438.230	Subcontractual Relationships and Delegation	Standard VIII—Subcontractual Relationship and Delegation		X	
§438.236	Practice Guidelines	Standard I—Practice Guidelines			X
		Standard VIII—Subcontractual Relationships and Delegation		X	
§438.242	Health Information Systems	Standard III—Health Information Systems			X
§438.330	Quality Assessment and Performance Improvement Program	Standard II—Quality Assessment and Performance Improvement Program			X

6. Follow-Up on Prior EQR Recommendations

Introduction

This section presents **DVHA**'s responses and a description of actions it took or is taking to address HSAG's recommendations made in the prior year's EQR report. The report included HSAG's recommendations to improve **DVHA**'s performance related to HSAG's findings from validation of **DVHA**'s performance improvement project and performance measures, and the review of its performance in complying with the federal Medicaid managed care regulations and associated AHS IGA requirements.

Validation of the Performance Improvement Project

During the previous EQR contract year (2020–2021), HSAG validated **DVHA**'s PIP, *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment*. The validation process included **DVHA**'s submission of the PIP and HSAG's completion of the validation tool. For the ten steps validated, **DVHA** completed and HSAG assessed, **DVHA** received a score of *Met* for 100 percent of the evaluation elements. There were no recommendations included in the PIP validation tool; however, HSAG provided the following recommendations in the annual PIP validation report.

Table 6-1—Performance Improvement Project—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Response/Actions/Outcomes
DVHA should retire the *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* PIP from submission for validation at the direction of AHS. **DVHA** submitted the PIP for four annual validations. HSAG validated the PIP through Step X, and **DVHA** achieved sustained improvement. **DVHA** should continue its quality improvement efforts for the topic to further sustain improvement in the study indicator results. **DVHA** should continue to evaluate the intervention for effectiveness. If the results indicate a decline after the PIP has ended, **DVHA** should add additional interventions as needed, evaluate the changes for effectiveness, and continue to monitor the study indicator data. **DVHA** should begin a new PIP if appropriate, at the direction of AHS, that would be submitted for an annual validation in 2021–2022.	**DVHA response:** **DVHA**'s submission of the IET PIP Summary Report in July 2020 marked the completion of the PIP team project work on this topic. **DVHA**'s work on both SUD treatment and telehealth expansion continues. Members of this PIP team remain engaged with various stakeholder groups on both topics. **DVHA** has continued to evaluate our performance on initiation of alcohol and other drug abuse or dependence treatment. Results continue to indicate sustained improvement. **DVHA** selected a new PIP topic in the fall of 2020 focusing on management of hypertension. **DVHA** submitted an annual summary for validation in May 2021.

Validation of Performance Measures

HSAG validated 15 performance measures during the previous EQR contract year (2020–2021). HSAG auditors determined that all 15 were compliant with AHS' specifications and that the rates could be reported. As a result of HSAG's review of provided documentation and a Webex audit, HSAG described the following areas for improvement.

Table 6-2—Performance Measure—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Response/Actions/Outcomes
While COVID-19 restricted many of the potential areas for improvement in measurement year 2020, prior HSAG recommendations noted that **DVHA** should continue to strengthen medical record retrieval processes to achieve improved medical record retrieval rates.	**DVHA response: DVHA**'s Provider Member Relations Unit staff outreached providers who were refusing to submit records or were requesting a fee to submit records to ensure that as many records as possible were retrieved. In June 2021, **DVHA** took the step to withhold 10% of Medicaid payments for seven providers who were withholding records. **DVHA** was able to get 303 of 324 records submitted by taking this action. **DVHA** had the highest annual record retrieval rate yet of 99.02%. **DVHA** plans to follow the same process next year.

Monitoring Compliance With Standards

During the 2020–2021 compliance audit, HSAG evaluated the degree to which **DVHA** complied with federal Medicaid managed care regulations and the associated AHS-**DVHA** IGA (i.e., contract requirements) in eight performance categories (i.e., standards). The eight standards included requirements associated with federal Medicaid standards found at 42 CFR §438.214–230. The standards HSAG evaluated were those related to the following:

I. Provider Selection
II. Credentialing and Recredentialing
III. Beneficiary Information
IV. Beneficiary Rights
V. Confidentiality
VI. Grievance System—Beneficiary Grievances
VII. Grievance System—Beneficiary Appeals and State Fair Hearings
VIII. Subcontractual Relationships and Delegation

HSAG reviewed this same set of standards during the 2008–2009, 2011–2012, 2014–2015, 2017–2018, and 2020–2021 compliance reviews.

The standards included, but were not limited to, performance requirements for **DVHA**'s processes and related documentation for:

- Selecting individual practitioners and organizational providers.
- Credentialing and recredentialing individual practitioners and organizational providers.
- Ensuring that beneficiaries receive all required information and that the information is available and provided at a level and in a language and format that make it easy for beneficiaries to understand.
- Informing beneficiaries about their rights and ensuring that their rights are protected.
- Protecting the confidentiality of beneficiary information.
- Receiving and responding to beneficiary grievances/complaints.
- Receiving and responding to beneficiary appeals and requests for State fair hearings.
- Ensuring that subcontracts and written delegation agreements include all required provisions and conducting all required activities associated with delegating one or more of **DVHA**'s administrative functions to another entity.

HSAG reviewed **DVHA**'s performance related to 88 elements across the eight standards. Of the 88 requirements, **DVHA** obtained a score of *Met* for 78 elements, a score of *Partially Met* for nine elements, and a score of *Not Met* for one element. As a result, **DVHA** obtained a total percentage of compliance across the 88 requirements of 93.8 percent, for which HSAG offered suggestions to **DVHA** to further strengthen its processes, performance, and documentation.

Table 6-3—Monitoring Compliance With Standards—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Responses/Actions/Outcomes
DVHA must ensure that every file processed for revalidation includes a malpractice insurance certificate that is valid on the date of reverification.	**DVHA response:** This been implemented and Gainwell is in the process of validation checks.
DVHA must include language in its member handbook regarding how beneficiaries are to report suspected fraud and abuse as required in 42 CFR and in the AHS-**DVHA** IGA.	**DVHA response: DVHA** will update the Member Handbook to include language which instructs beneficiaries how to report suspected fraud and abuse as required by 42 CFR by 1/1/2022.
DVHA must ensure that all grievances are addressed within 90 calendar days of receipt of the grievance. Written notices also must contain a brief summary of the grievance, information considered in making the grievance decision, and the disposition. If the response is adverse to the beneficiary, the notice also must inform the beneficiary of the right (and how) to initiate a grievance review.	**DVHA response:** A follow-up was done with the designated agencies with a reminder of the required process. **DVHA** will schedule a training for all coordinators by 3/1/2022. The Medicaid Compliance Officer will follow up in May of 2022 to ensure compliance with the timeline requirements.

HSAG Recommendations	DVHA Responses/Actions/Outcomes
DVHA must ensure that an acknowledgement letter is sent within five calendar days of receiving the grievance.	**DVHA response:** A follow-up was done with the designated agencies with a reminder of the required process. **DVHA** will schedule a training for all coordinators by 3/1/2022. The Medicaid Compliance Officer will follow up in May of 2022 to ensure compliance with the timeline requirements.
DVHA must ensure that the written notice of grievance resolution contains the required information.	**DVHA response:** A follow-up was done with the designated agencies with a reminder of the process. **DVHA** will schedule a training for all coordinators by 3/1/2022. The Medicaid Compliance Officer will follow up in May of 2022 to ensure compliance with notice language requirements.
DVHA must ensure that grievance files include information about the individual making the grievance decision.	**DVHA response:** The manual will be updated by 1/1/22 to reflect this requirement. A follow-up was done with the designated agencies with a reminder of the process. **DVHA** will schedule a training for all coordinators by 3/1/2022. The Medicaid Compliance officer will follow up in May of 2022 to ensure that the grievance files indicate the decision-maker.
DVHA must ensure that its IGA partners, including designated agencies and specialized service agencies acting within the delegated authority of **DVHA**/Department of Mental Health (DMH) adhere to the policies and procedures.	**DVHA response:** A follow was done with the designated agencies with a reminder of the required process. **DVHA** will schedule a training for all coordinators by 3/1/2022. By April of 2022, the Medicaid Compliance Officer will update the departmental IGAs to more clearly describe the required process and a system for monitoring compliance with this standard.
DVHA must ensure that the department which receives the appeal mails written acknowledgement of the appeal within five calendar days of receipt as required by State rule.	**DVHA response:** A follow-up was done with the designated agencies with a reminder of the required process. **DVHA** will schedule a training for all coordinators by 3/1/2022. The Medicaid Compliance Officer will follow up in May of 2022 to ensure compliance with the timeline requirements.

HSAG Recommendations	DVHA Responses/Actions/Outcomes
DVHA must ensure that appeals are resolved and that members are provided written notice within the maximum time frames for standard and expedited appeals, including any extensions.	**DVHA response:** A follow-up was done with the designated agencies with a reminder of the required process. **DVHA** will schedule a training for all coordinators by 3/1/2022. The Medicaid Compliance Officer will follow up in May of 2022 to ensure compliance with the timeline requirements.
DVHA must ensure that appeal resolution letters include information pertaining to members' rights to request a State fair hearing.	**DVHA response:** A follow-up was done with the designated agencies with a reminder of the process. **DVHA** will schedule a training for all coordinators by 3/1/2022. The Medicaid Compliance Officer will follow up in May of 2022 to ensure compliance with notice language requirements.